

**SELECT COMMITTEE ON
SCIENCE AND TECHNOLOGY**

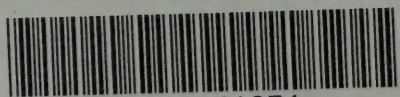
**MEDICAL RESEARCH AND
THE NHS REFORMS**

**EVIDENCE RECEIVED FROM
JANUARY 1995**

Printed pursuant to the Order of the House of Lords of 22 November 1994

LONDON: HMSO

£35.50 net



22501851671

CONTENTS

Page

ORAL EVIDENCE

<i>Council of Deans of Dental Schools</i>	
Written evidence	107
Oral evidence, 17 January 1995	108
Supplementary evidence	110

**SELECT COMMITTEE ON
SCIENCE AND TECHNOLOGY**

<i>Royal College of General Practitioners</i>	
Written evidence	121
Oral evidence, 24 January 1995	122

<i>NHS Centre for Reviews and Dissemination and the UK Cochrane Centre</i>	
Written evidence	131
Oral evidence, 31 January 1995	133

<i>NHS R&D</i>	
Written evidence	140
Oral evidence, 31 January 1995	143
Supplementary evidence	146

**MEDICAL RESEARCH AND
THE NHS REFORMS**

<i>NHS Executive</i>	
Written evidence	147
Oral evidence, 7 February 1995	149

<i>Dr Malcolm Gissen</i>	
Written evidence	159
Oral evidence, 7 February 1995	161

**EVIDENCE RECEIVED FROM
JANUARY 1995**

<i>Queen's University of Belfast</i>	
Written evidence	169
Oral evidence, 14 February 1995	171

<i>Northern Ireland Department of Health and Social Services</i>	
Oral evidence, 14 February 1995	176

<i>Dr Peter Doyle</i>	
Written evidence from the University of Manchester	185
Oral evidence, 15 February 1995	186

<i>Professor John Seale</i>	
Written evidence	193
Oral evidence, 15 February 1995	195
Supplementary evidence	197

INFORMATION SERVICE

X PW
HGV -5 JUL 1995
6434

Wellcome Centre for Medical Science

Printed pursuant to the Order of the House of Lords of 22 November 1994

<i>National Association of Health Authorities and Trusts</i>	
Oral evidence, 21 February 1995	213

<i>Written evidence from the University of Aberdeen</i>	251
<i>Written evidence from the University of Glasgow</i>	252
<i>Letter from Professor D J H Brock, University of Edinburgh</i>	254
<i>Written evidence from the Council of the Royal Society of Edinburgh</i>	255
<i>Written evidence from the Edinburgh Hospital Endowment Research Trust</i>	256

LONDON: HMSO
£35.50 net

CONTENTS

	<i>Page</i>
ORAL EVIDENCE	
<i>Council of Deans of Dental Schools</i>	
Written evidence	107
Oral evidence, 17 January 1995	108
Supplementary evidence	118
<i>Royal College of General Practitioners</i>	
Written evidence	121
Oral evidence, 24 January 1995	136
<i>NHS Centre for Reviews and Dissemination and the UK Cochrane Centre</i>	
Written evidence	151
Oral evidence, 31 January 1995	153
<i>NHS R&D Task Force</i>	
Written evidence	168
Oral evidence, 31 January 1995	183
Supplementary evidence	196
<i>NHS Executive</i>	
Written evidence	197
Oral evidence, 7 February 1995	200
<i>Dr Malcolm Green</i>	
Written evidence	209
Oral evidence, 7 February 1995	214
<i>Queen's University of Belfast</i>	
Written evidence	219
Oral evidence, 14 February 1995	224
<i>Northern Ireland Department of Health and Social Services</i>	
Oral evidence, 14 February 1995	236
<i>Dr Peter Doyle</i>	
Written evidence from the Association of the British Pharmaceutical Industry	245
Oral evidence, 15 February 1995	246
<i>Professor John Swales</i>	
Written evidence	253
Oral evidence, 15 February 1995	255
Supplementary evidence	261
<i>Conference of Medical Royal Colleges</i>	
Written evidence	262
Oral evidence, 21 February 1995	265
Supplementary evidence	272
<i>National Association of Health Authorities and Trusts</i>	
Oral evidence, 21 February 1995	273
Written evidence from the University of Aberdeen	282
Written evidence from the University of Glasgow	283
Letter from Professor D J H Brock, University of Edinburgh	284
Written evidence from the Council of the Royal Society of Edinburgh	284
Written evidence from the Scottish Hospital Endowments Research Trust	286

<i>Committee of Scottish Higher Education Principals</i>	
Oral evidence, 28 February 1995	287
<i>Royal Society of Edinburgh</i>	
Oral evidence, 28 February 1995	296
Supplementary evidence	313
<i>Scottish Office Home and Health Department</i>	
Oral evidence, 28 February 1995	306
Supplementary evidence	315
<i>Association of Young Medical Scientists</i>	
Written evidence	318
Oral evidence, 7 March 1995	319
Supplementary evidence	327
<i>Royal College of Nursing</i>	
Written evidence from the Royal College of Nursing	327
Written evidence from Professor J J A Robinson, University of Nottingham	335
Written evidence from the Royal College of Midwives	338
Oral evidence, 7 March 1995	340
<i>Professor Michael Peckham, Professor Sir Miles Irving, Professor Stephen Holgate, Professor George Alberti and Professor Andrew Haines</i>	
Written evidence from Professor Stephen Holgate	347
Written evidence from Professor Sir Miles Irving	349
Written evidence from the Department of Health	353
Oral evidence, 14 March 1995	373
Written evidence from Professor Michael Peckham	381
Supplementary evidence from the Department of Health	384
<i>Council for Professions Supplementary to Medicine</i>	
Oral evidence, 14 March 1995	386
Supplementary evidence	392
<i>Higher Education Funding Councils for England and Scotland</i>	
Written evidence	393
Oral evidence, 21 March 1995	396
Supplementary evidence	402
<i>British Medical Association</i>	
Written evidence	403
Oral evidence, 21 March 1995	407

WRITTEN EVIDENCE

Arthritis and Rheumatism Council	412
Association of British HealthCare Industries	414
Association of Medical Research Charities	416
Association of University Departments of General Practice	426
Professor Alasdair Breckenridge, Regional Director of R&D, North West RHA	429
British Dental Association	431
Central Manchester Healthcare NHS Trust	433
Council of Deans of Dental Schools	437
Council of Science and Technology Institutes, Health Care Scientific Advisory Committee	437
Engineering and Physical Sciences Research Council	442
Guy's and St Thomas's United Medical and Dental School	444
Heads of University Centres of Biomedical Science	445
Imperial Cancer Research Fund	445
Institute of Biomedical Science	448
Institute of Physical Sciences in Medicine	448
Institution of Mechanical Engineering	449

King's College School of Medicine and Dentistry	451
Leukaemia Research Fund	451
Lewis-Emerton Associates	452
Medical Journalists' Association	453
Medical Research Council	454
Office of Science and Technology	455
Royal Academy of Engineering	458
Council of Deans of Medical Schools	462
Royal Society	462
Society for Research in Rehabilitation	463
South Sefton Research Ethics Committee	465
Standing Committee on Postgraduate Medical and Dental Education	466
Professor E J Thomas, Faculty of Medicine, University of Southampton	472
University of Leicester, School of Medicine	473
University of Manchester, Faculty of Medicine	473
University of Ulster	476
University of Wales, College of Medicine	478
University of Warwick	478
Welsh Office Health Department	479

link between education, training and practice. However the pace of change has to be mitigated so that institutions have time to adapt to change, funding must be put in place and resources correctly allocated to the new mechanisms of funding to be introduced and this needs to be done in a way which is manageable and safety nets will need applying.

2. The Council of Deans of Dental Schools expresses support for the comments made by the Secretary of State for Health in respect of the Collyer report. In particular we consider it important that funding for R&D is ring-fenced at least until 1996 and possibly in the interim to protect the research needs of teaching hospitals.

3. Partnership with the Universities, Research Councils and Charities is fundamental to planned development as is accountability in types of work done and use of resources. We have no objections to proper systems of auditing and accountability in relation to the expenditure of NHS funds on dental research. However these should be based on thorough, objective studies of the true cost and current sources of funding.

4. The Council agrees that present methods in NHS funding of research may be haphazard and this problem must be addressed, possibly by appropriate and wide representation on Regional Research Bodies.

5. In addition to the concerns the Government's Oral Health Strategy for England was not an integral part of the Health of the Nation and because dentistry is often considered separable from medicine, it is important to ensure that Regional Research Committees and Directors of R&D recognise that their remit incorporates dental research. It is necessary therefore for them to seek appropriate advice on dental matters, extending from the identification of priority areas through to the refereeing of grant applications. Such advice must be balanced, based and not focused entirely on one individual. The NHS Director of R&D should therefore undertake to ensure that the Strategy for NHS R&D fully embraces the special requirements for research in dentistry and oral cancer.

6. The Council is concerned that the internal market for NHS services may conflict with research priorities. This is particularly so where competition exists for patient treatment which may affect adversely the critical mass of clinical material required to conduct and report on many of the trials.

7. We are the owners of a public health system has obligations that require contacts to be of good quality and of the R component of SIFTR. Although this is supposedly taken into account in contract negotiations with providers it should be possible to avoid this. We are extremely concerned that SIFTR remains based on industry interests rather than patient care and that the fact that there is no SIFTR does not identified for dental postgraduate studies.

8. In addition it does not appear that the cost of the R component of Dental SIFTR has been adequately calculated. A recent for tooth analysis in some parts of dentistry has demonstrated that almost 5 per cent of NHS expenditure on salaries can be allocated to research, which might be a reasonable estimate of research expenditure in a Dental Hospital/School. There is a need for a more realistic estimate of the proportion of our resources which is available for research and development.

9. The proposal to remove the R component of SIFTR funding could have serious consequences for dental research. At present Dental SIFTR provides virtually 50 per cent of the funding of Dental Hospitals and the R component representing some 5 per cent of the infrastructure costs is also closely protected and is actually withdrawn from the budget of Dental Hospitals each at 2 per cent would represent a level of cuts which would bring planning and development of the provision of services and of teaching. In addition, there is a distribution of Medical SIFTR and it specifically for the teaching of medical subjects in dental schools. This was used as a basis to develop dental teaching hospitals for providing the facility and again a reduction of 50 per cent of a medical subject SIFTR. There can be no the coverage of the actual infrastructure expenditure of dental research in a Dental Hospital, which is the basis of the removal of

TUESDAY 17 JANUARY 1995

Present:

Gregson, L.
Nathan, L.
Perry of Southwark, B.

Perry of Walton, L.
Selborne, E.
Walton of Detchant, L.
(Chairman)

Memorandum by the Council of Deans of Dental Schools

The Council of Deans of Dental Schools thanks the Select Committee for its request to produce evidence for the above enquiry. The proposals for the development of the NHS R&D Strategy are far reaching and it is appropriate that the clinical academic establishment is consulted in this development, as it is only by close co-operation and mutual understanding that the optimum benefit can be gained in improving the future health of the nation. The following comments are submitted to the Committee.

1. The NHS R&D strategy as a whole has much to commend it, in particular the way in which it fosters links between academic units and provider Trusts. However the pace of change has to be managed so that institutions have time to adapt to the new funding mechanisms and to position themselves correctly in relation to these new mechanisms. If funding is to be reduced then this needs to be done in a way which is manageable and safety nets will need applying.

2. The Council of Deans of Dental Schools expresses support for the comments made by the Secretary of State for Health in respect of the Culyer report. In particular we consider it important that funding for R&D is ring-fenced at least until 1996 and possibly in the future to protect the research costs of teaching hospitals.

3. Partnership with the Universities, Research Councils and Charities is fundamental to planned development as is accountability in respect of work done and use of resource. We have no objections to proper systems of costings and accountability in relation to the expenditure of NHS funds on dental research. However these should be based on thorough, objective studies of the true cost and current sources of funding.

4. The Council agrees that present methods in NHS funding of research may be haphazard and this problem must be addressed, possibly by appropriate and wide representation on Regional Research Bodies.

5. In addition partly because the Government's Oral Health Strategy for England was not an integral part of the Health of the Nation and because dentistry is often considered separately from medicine, it is important to ensure that Regional Research Committees and Directors of R&D recognise that their remit incorporates dental research. It is necessary therefore for them to seek appropriate advice on dental matters, extending from the identification of priority areas through to the refereeing of grant applications. Such advice needs to be broadly based and not focussed entirely on one individual. The NHS Director of R&D should therefore be advised to ensure that the Strategy for NHS R&D fully embraces the special requirements for research into dentistry and oral disease.

6. The Council is concerned that the internal market for NHS services may conflict with research priorities. This is particularly so where competition exists for patient treatment which may affect adversely the critical mass of clinical material required to conduct and report on meaningful trials.

7. While the concept of a single funding stream has attractions there remains concern in respect of possible loss of the R component of SIFTR. Although this is supposedly taken into account in contract negotiations with purchasers its removal may eventually result in its loss. We are extremely concerned that SIFTR remains based on student numbers rather than capital estate and also the fact that there is no SIFTR element identified for clinical postgraduate studies.

8. In addition it does not appear that the cost of the R component of Dental SIFTR has been undertaken nationally. Knock for knock analysis in some areas of dentistry has demonstrated that almost 5 per cent of NHS expenditure on salaries can be attributed to research, which might be a reasonable estimate of research expenditure in a Dental Hospital/School. There is a need for some estimate of the proportion of our function which is associated with research and development.

9. The proposal to remove the R component of SIFTR funding could have serious consequences for dental Hospitals. At present Dental SIFTR provides notionally 85 per cent of the funding of Dental Hospitals and the R component representing some of the infrastructure costs is also entirely notional and is actually unknown. Its removal from the budget of Dental Hospitals; even at 5 per cent would represent a level of uncertainty that would blight planning and have an effect on the provision of services and of teaching. In addition, there is a contribution of Medical SIFTR that is specifically for the teaching of medical subjects to dental students. This was used as a device to compensate District General Hospitals for providing the facility and again was notional (10 per cent of a medical student's SIFTR). There have been no true costings of the actual infrastructure requirements related to research in Dental Hospitals, there is no logic to the removal of

*17 January 1995]**[Continued]*

these costs from SIFTR and no basis for their re-allocation. The prospect of serious harm to dental teaching, through the potential effects of this proposed policy on Dental Hospitals is significant.

10. This concern is reinforced by the statement in paragraph 15 of the Recommendations concerning the Dental Curriculum of the General Dental Council published in May 1990—"It is important that in every dental school proper facilities should be provided for research...".

11. The establishment of clinical research ratings may be of some value, and the suggestion that infrastructure support money might be distributed through HEFCE has some attractions although there could be difficulties with non-teaching hospitals (less of a problem in dentistry). If a formalised assessment by research ratings is to be implemented, then we believe that the national "pot of gold" for dental research should be safeguarded, and supplemented if a cost analysis shows this to be significantly lower pro rata than in medicine. However the research ratings must be focussed on the benefits to the NHS R&D Strategy and it would be inappropriate to use the similar HEFCE exercise as proxy for them.

12. The majority of dental research in the UK is carried out in Dental Schools and their associated Dental Hospitals. Dental Hospitals exist only in relation to Dental Schools, for which they provide essential clinical teaching facilities. For Dental Schools to continue to thrive as centres of research activity, it is essential that the provision of clinical support facilities for research in Dental Hospitals is not compromised by changes in resource allocation. There are sufficient differences between medicine and dentistry organisationally to indicate caution in the transference of a medical model of funding into a dental context.

13. The Council is concerned therefore that the development of clinical research may be adversely affected by the clinical requirements of purchasers, inflexible Job Plans and unrealistic clinical training periods for clinical academics. It is adamant that University research priorities must not be dictated by NHS requirements related to the internal market or by the need simply to demonstrate rapid achievement of health gains.

In placing these views before the Select Committee for the current meeting, the Council welcomes the opportunity to add to these submissions before the end of January 1995.

5 January 1995

Examination of witnesses

Professor W R E LAIRD (Chairman of CDDS), University of Birmingham, PROFESSOR F P ASHLEY, University of London, Guy's Hospital, PROFESSOR W HUME, University of Leeds, PROFESSOR C SMITH, University of Sheffield and PROFESSOR A H BROOK (Secretary of CDDS), University of London, London Hospital Medical College, from the Council of Deans of Dental Schools (CDDS), were called in and examined.

Chairman

236. Good morning, gentlemen, welcome. We have of course seen and read the papers which have been put before us by Professor Laird on behalf of your group, and by Professor Johnson, and you may or may not be aware that Professor Gainsford also wrote to us back in November making some comments about dental research. Do you wish to make an opening statement, Professor Laird?

(*Professor Laird*) I do not think so, my Lord Chairman. I think what we have said in our submission gives an idea of how we would wish to proceed. We do welcome, obviously, the opportunity to give this evidence.

237. Thank you. We have just had circulated to us a note by the Clerk about the MRC's scientific strategy for 1994, and also a comment about funding of dental research by the Wellcome Trust. He has also discovered some bibliometric evidence provided by PRISM, the Wellcome Trust's unit for Policy Research in Science and Medicine, indicating that the UK's share of world publications in dentistry research is around 13 per cent, and more details are given to us. So we would like your comments on the standing of UK dentistry research and would like to know the evidence suggesting it is as high as Professor Johnson claims; we would also like to know what the centres of excellence are, where they

are and what are the major areas of scientific advance?

(*Professor Laird*) Dental research in the United Kingdom we believe has a high international reputation; we would agree with those comments. It has a high rating and this is reflected by the numbers of papers which are submitted and accepted into peer reviewed journals, not just in the United Kingdom but throughout the world. Many research workers in the United Kingdom have received international recognition in the form of prizes, and in the form of invitations to attend to present before international bodies. Clearly these lists are fairly extensive and I could not give you individual lists at this stage, but suffice to say the dental researchers in the United Kingdom are in demand for their skills and their knowledge on an international basis.

238. Did any dental department in the UK receive a grading of 5 from the Higher Education Funding Councils in their recent assessment exercise?

(*Professor Laird*) Two of the dental schools in the United Kingdom received a grading of 5. I think it is important that we understand that although individual schools may not be given a grading of 5 they may have individual strengths, and there are particular strengths in areas such as dental public health, bio-materials, immunology, craniofacial development, oral biology, which are spread throughout the schools in the United Kingdom and are not necessarily centred in one single school. This

17 January 1995]

PROFESSOR W R E LAIRD, PROFESSOR F P ASHLEY,
PROFESSOR W HUME, PROFESSOR C SMITH AND
PROFESSOR A H BROOK

[Continued]

[Chairman contd.]

is an important factor in dental research, that it is actually widespread throughout the country and there are centres of excellence throughout the country as well.

Lord Perry of Walton

239. What is the current number of dental schools?
(*Professor Laird*) Thirteen.

Chairman

240. How many were closed? Was it two that were closed?

(*Professor Laird*) Yes, two.

241. Would you like to tell us in what respects dental research differs from medical research? How is it organised and funded? In particular what is the infrastructure support for dental research which comes from the NHS?

(*Professor Smith*) Most of the dental research in this country takes place in dental schools, there is very little that takes place outside dental schools. I think that is a difference compared with medicine. The funding for it largely comes through the HEFC support for dental schools. There is comparatively little funding, and it is difficult to identify how much, which comes through the National Health Service to dental hospitals. The dental hospitals exist really to support the teaching function of the dental schools.

242. Does that in effect mean that it is possible, and here I speak as someone who was once a dean of a medical school with an associated dental school and hospital, precisely to distinguish the funding of dental schools on the one hand from dental hospitals on the other? Or is there a grey area of overlap between the two?

(*Professor Smith*) I think it is possible to identify fairly precisely the funding routes but there are activities where blurring occurs.

Lord Perry of Walton

243. Professor Johnson in his letter said that the UK spends £1.8 million each year on dental research. He said, "This is a tiny proportion of the cost of NHS dentistry ...", which he says totals £1½ billion, and suggests that the 1½ per cent is what is really needed. That would then come to £24 million divided between 13 schools. Could it be used? Is there any conceivable way of spending that much money on dental research at the moment?

(*Professor Smith*) I think the problem with dental schools is in providing sufficient training opportunities for young people and career opportunities for research workers within dentistry. I believe that is where the investment should take place. If that investment took place, there would be opportunities subsequently for further development of research.

Chairman

244. If you were planning to carry out some kind of controlled trial of a specific method in the treatment of a particular dental condition, this would require involvement of patients and the involvement

of a dental hospital, so how would the actual service costs of that kind of trial be covered?

(*Professor Laird*) The service costs of a trial like that would be covered by grant applications, almost certainly, to one of the funding bodies which would provide the necessary funding infrastructure for the use of clinical facilities. It would be very difficult, I believe, in the current climate to fund a large trial like that purely on the money which is coming in through the variety of sources which we receive our money from, such as the HEFCE and the SIFTR allowances. I think a trial like that would have to be supported by a grant.

245. Would that grant money then go to the dental school and through it to the university, or would it go to the actual dental hospital?

(*Professor Laird*) It would depend very much on the arrangements in the individual dental school and university. If I can speak for my own dental school, the money would come firstly to the university and then would be dispersed to the hospital according to the infrastructure which was provided.

246. Is it not possible that that infrastructure support for a clinical trial, for example, could be covered from the SIFTR money?

(*Professor Ashley*) I think in theory, yes, but the work that has been done in dental hospitals indicates that the R component of our SIFTR expenditure is extremely low. In some hospitals they have said that it cannot be identified. One of the difficulties is that in most cases patients who are coming in for a clinical trial are coming in and having treatment. The clinical trial may be taking place but they are having treatment, so many hospitals would say: "Well, this is being covered on that basis". They would not count that as being an additional cost although often there is an additional cost: the patient may be in the hospital for longer and have more visits and so on. Can I also just clarify one point, in case you misheard: the £1.8 million of course that Professor Johnson referred to does not include our Higher Education Funding Council Research element which dwarfs that. If you add up all the research income that we get from the university side into the schools and consider that as being research income—

247. Can you give us any information which will indicate roughly what proportion of funding of the existing dental schools comes from the HEFCs and what proportion would come from soft money through grants?

(*Professor Ashley*) In relation to research?

248. Yes?

(*Professor Ashley*) Purely?

249. Yes.

(*Professor Ashley*) A much higher proportion from the Higher Education Funding Council than from soft money.

250. Yes.

(*Professor Ashley*) In my own school I would say it is a ratio of probably three to one.

251. Is there a possibility that you might, through contacting your colleagues in other dental schools, be able to give us some exact figures relating to HEFC

17 January 1995]

PROFESSOR W R E LAIRD, PROFESSOR F P ASHLEY,
PROFESSOR W HUME, PROFESSOR C SMITH AND
PROFESSOR A H BROOK

[Continued]

[Chairman *contd.*]

support on the one hand and grant money on the other?

(*Professor Laird*) I believe we could.

Lord Gregson] It would be possible, Lord Chairman, to include other sources of funding as well.

252. Indeed. Other sources of money, and by which we mean commercial organisations, the European Union and charities, yes, of course.

(*Professor Laird*) We will collect such information.

Earl of Selborne

253. Once we have got these figures what we would like to be able to determine is where your core funding is coming from at the moment, the different sources you described, and how this compares with what you might call the soft money? Could you meanwhile give us some feel as to how successful the dental schools have been in retaining adequate core funding in the past, bearing in mind your concern that future procedures are likely to cause you some concern?

(*Professor Laird*) I would like Professor Smith to give you some figures on that in relation to the last HEFC exercise which will be helpful.

(*Professor Smith*) I am sorry, Chairman, I cannot do that immediately.

254. You told us in your evidence that you believe that if these recommendations are implemented you will want a safety net, you will need to see there is a ring fenced element until 1996 at least.

(*Professor Smith*) Yes.

255. It suggests that while you are presumably not satisfied with the amount of core funding you have at the moment you are concerned that new arrangements are going to be even worse. I wonder if you could describe what your fears are based on?

(*Professor Ashley*) If I may answer this. We have been subjected, as you know, as the universities have been subjected, to cost efficiency savings and as with most universities and hospitals our major expenditure is on staff. So if say a decision was taken that less than five per cent of our SIFTR income is in the R category as opposed to 25 per cent of the medical SIFTR income even that is a substantial amount for a dental hospital. In my own case I think my total SIFTR income is in the order of about four million pounds. So if you take out five per cent of that suddenly and put it into another pot which we have to compete for this can produce instability. Now obviously it produces opportunities but if you have winners you have losers in that situation and we are really saying that as the changes in the research income on the university side have been managed these would have to be managed so the changes in one year would not be greater than any institution could cope with. That is the point we were trying to make there.

256. It does suggest the R element of SIFTR, while it is not adequate for your purposes, it is still quite important.

(*Professor Ashley*) The most recent press release said that it has been set at 25 per cent of the medical

SIFTR but the dental component was a matter for further investigation.

(*Professor Smith*) If I may, Chairman, the important point is that a very high proportion of the funding of dental hospitals comes through SIFTR. The notional national average is 85 per cent. Even if the R component is as low as five per cent, which is inadequate but if it is that, then five per cent of 85 per cent is a fairly high proportion of one's funding compared with, say, a district general hospital which might receive ten per cent of its funding through SIFTR, of which the R component is 25 per cent.

Chairman

257. Can we clarify in relation to that the source of the patients who come to your dental hospitals? You are not faced with the same kind of purchaser/provider system, or are you?

(*Professor Brook*) Yes.

258. Well, now in that case how many patients just come in off the street seeking treatment and how many are referred for special treatment by dental practitioners in the community?

(*Professor Laird*) I do not think we could give you exact figures on that, my Lord, obviously, but a substantial number of patients come in simply off the street for primary care treatment which is carried out by our students under supervision. Indeed most dental hospitals would see themselves as a large dental practice serving an area—a very large area obviously but nevertheless a dental practice serving an area. We have also secondary care patients who are referred to us from general dental practitioners. These patients may or may not be treated by dental hospital staff, either a consultant grade or in a training grade. They may also be treated by students if the type of treatment which is required is deemed to be suitable for teaching purposes. So there is a substantial number of patients who simply come in off the street, a very high proportion, much higher than the numbers that are referred for secondary care.

259. Just to clarify this, one of the problems we have been told about in medicine is that in highly specialised units the tertiary referrals, meaning referrals from district general hospitals to centres of excellence, have been under threat because the purchasers will not pay the additional service costs required for such referrals. Is this a problem you have encountered in dentistry? Is there any reduction in the number of referrals from dental practitioners? Who pays for those specialised referrals?

(*Professor Hume*) These are very complicated issues, my Lord Chairman.

260. Yes.

(*Professor Hume*) The internal market in my opinion has not been applied successfully to the running of dental schools and dental hospitals. The Department of Health and the NHMSE currently have working groups looking at the whole question of the funding of dental hospitals. The difficulty is compounded by the fact that the Government's document "Improving NHS Dentistry" has still not led to a conclusion as to how dentistry in the high street is going to be funded. We are gradually—and I

17 January 1995]

PROFESSOR W R E LAIRD, PROFESSOR F P ASHLEY,
PROFESSOR W HUME, PROFESSOR C SMITH AND
PROFESSOR A H BROOK

[Continued]

[Chairman *contd.*]

am sure my colleagues will agree—turning away more and more patients from our dental hospitals because the patients are being referred inappropriately either because the patient cannot afford the NHS fee for general dental treatment and “Can you please send me down to the dental hospital to have it done by students or staff”, or secondly because the practitioners claim they cannot afford to undertake the work on the NHS and therefore would we please do that work. I think as far as a safety net is concerned, dental hospitals provide a massive safety net to patients and this is something that has to be managed and there are considerable problems. That is one aspect of the question. The other is in terms of tertiary referral, if I might just widen that slightly more. I think there is a number of problems here. In the field of dental implants, for example, dental hospitals are centres of excellence. If the practitioners of the future are to learn up-to-date techniques they must get some experience of what can be achieved in dental hospitals. A number of dental schools are in a rather difficult position where they have entered into contracts for dental implants. These are titanium screws put into the bone for a number of reasons and they are expensive. The district health authorities, certainly in our region, are rather reluctant to fund this type of work. If we were to say to them that we have to decongest the system, the prices must go up or the activity must go down, so we can spend time on research, I do not think that the priority of dentistry with the purchasers and their agenda would be such that it would be feasible. Therefore there is a considerable problem here in terms of how we deal with the internal market.

261. Effectively your purchasers then are the health authorities and trusts. You are not then—or are you—required to charge dental practitioners for tertiary referrals?

(*Professor Hume*) No, my Lord, there is no mechanism for that.

262. That is what I thought. So there is nothing comparable, for instance, to the fundholding general practitioners in medicine?

(*Professor Hume*) Not at present, but there has been some attempt to introduce total purchasing by medical practitioner fundholders to include dentistry.

Baroness Perry of Southwark

263. I want to switch tack from the general funding of research to look at the people who do the research and your concerns about the clinical academics. First of all I wondered what you meant by “unrealistic clinical training periods”, are you talking about too long or too short when you say that? Then “inflexible job plans” you had in capital letters and I did not know whether you meant that as the job plan of the school as a whole, so perhaps you could explain that. Are they the same concerns as I think are in Professor Johnson’s fourth paragraph where he mentioned the need for a cultural shift because the academic staff are too heavily committed to teaching and supervising undergraduates to get on with their research?

(*Professor Hume*) As far as the job plans are concerned, the arrangement a few years ago when job plans were introduced for NHS consultants was that job plans would be agreed *en masse* between, for example, the dean of a dental school and the UGM. That, I think, tends to break down because in our school, for example, we have 29 academic staff in ten disciplines and you quickly get to a position where the senior academic consultant staff have really got to produce detailed job plans because it is unrealistic, because of the small numbers, to expect that cover can be produced elsewhere. There is some difference in interpretation of how consultant academic job plans should be implemented between one dental hospital and another, and I think that comes down to different interpretations or wishes between the academics on the one hand and the UGM on the other. We now have three dental institutes where the school and hospital have been merged into a single financial and managerial stream, and then the dean might be the director of the institute and hold the job plans for the academics and NHS consultants. Certainly in our own case in Leeds we see this as a very positive step forward to ensure we always address the appropriate balance for academics between undertaking NHS work and fulfilling their main responsibilities which are teaching and research. As far as the clinical training periods are concerned, I think we would like to draw to your Lordships’ attention a few points. The first one is that we do feel junior academic staff in dentistry have different expectations of their career pathways from their counterparts in medicine. Most of the junior academics come in as lecturers with no research training, no fellowship examinations and very little experience. Recruitment into dental schools is so difficult at the senior level that chairs go unfilled, and at the junior level we must provide the training programmes for our junior staff on the NHS side otherwise they will not be recruited. The training programmes for junior academics are far longer than their NHS counterparts, and this causes problems. Another problem is the fact that the university is paying a salary for the academic trainee whilst training is going on. The staffing in dental hospitals is so borderline that we cannot really afford the drain on our staffing resources for one junior member of staff being seconded for seven or eight sessions a week for NHS training. These issues tend to compound the time available for research.

264. I understand that. Why do you not see the structure of training your junior academics in research as part of the overall research activities of the school? I have in mind specific projects and ensuring that training comes that way and funding it not through academic salaries but through research grants?

(*Professor Hume*) I think that is difficult. There is really not a significant track record of junior staff being employed on two or three year training fellowships which allow them to go up this pathway. What we have to do is ensure we develop staff across the board. It is not possible, however, for staff to undertake PhD training at the same time as clinical training, and therefore the time needed to take people to a stage where they are making significant input

17 January 1995]

PROFESSOR W R E LAIRD, PROFESSOR F P ASHLEY,
 PROFESSOR W HUME, PROFESSOR C SMITH AND
 PROFESSOR A H BROOK

[Continued]

[Baroness Perry of Southwark *contd.*]

and return to dental schools is quite considerable. We do it, but the problem is that we have few staff to actually provide training and supervision as well.

Chairman

265. Just to follow that point up, and it is an important point which is often overlooked, in medicine (and I am sure the same is true in dentistry) it is the responsibility of the universities, through the money they get from the Higher Education Funding Councils, to provide facilities for post-graduate training leading to degrees at the universities, such as PhDs and so on, though many such grants come from research councils and other bodies. Under the NHS Act it is, however, the responsibility of the NHS to provide post-graduate vocational training for NHS consultancy appointments. How is that done in dentistry?

(*Professor Laird*) In the dental regions there will be a post-graduate dental dean who will be in charge of vocational training and additional training for people going on the NHS pathway. This will include not just junior hospital staff but also general practitioners who need advanced training as well, and the post-graduate deans will have a specific budget for this.

266. Thank you. It has been pointed out to me that in medicine two academic staff members employed by the university may carry out the amount of clinical work that one NHS consultant will undertake. Is that something which is true in dentistry?

(*Professor Laird*) Dentistry is very different from medicine in this respect, because much of the dental consultant work is undertaken by academic appointees. In most dental schools there are many more honorary consultants than there are substantive consultants in the NHS. The honorary consultant contract is designed to cover six sessions a week of what one might call "NHS activity". If one looks at it purely on a numerical basis, clearly two academic members of staff will do the same amount of work as one NHS member of staff, but I would hasten to add that it does not work like that.

267. I think that is also true of many places in medicine. I was rather surprised to hear you say, Professor Hume, that there is a lack of availability of training fellowships in dentistry either for research from the MRC or from any other funding organisation. Is this true?

(*Professor Hume*) Perhaps that was slightly loose wording, my Lord. We are certainly conscious, as Professor Smith has already alluded to, that we do feel that an increase in the number of training fellowships is necessary, partly for recruitment purposes and partly to ensure the best people are being given research training in scientific centres of excellence and then come back to dentistry. I think you have also got to give some thought as to whether the type of person who comes in to perhaps an academic post in dentistry is the same beast as his counterpart in medicine. Certainly we feel quite strongly that at the undergraduate level the dental student is a different beast from the medical student, he or she knows precisely what he or she wants to do after graduation. I think it partly relates to the

recruitment problem I had alluded to. Certainly if there were more fellowships for dentistry this would help us recruit good people in. Once we have recruited them in we do have a responsibility, however, to develop their careers. We are well aware of a number of staff who have developed well and they have reached a ceiling because there are no promoted posts available for them either at consultant level or a senior lectureship.

268. Just to follow that point up: are virtually all of the training fellowships funded by the MRC and Wellcome or are there any other sources that exist? Finally, to what extent are dental students able to divert from their mainstream of undergraduate training to undertake an intercalated honours degree such as a BSc?

(*Professor Smith*) I did want to introduce a possibly more optimistic note here.

269. Yes.

(*Professor Smith*) I think the recent increase in length of the dental undergraduate course to five years by an additional two terms, which was primarily to be directed to improving the teaching of basic medical and dental sciences, will improve the scientific base of dental students, will lead to more of them being encouraged to take up an intercalated degree (of which there has been a comparatively small number in the past) and has enabled many schools to introduce a research component into the undergraduate course. This will improve, one would hope, the perspective of dental students about research and encourage more of them to pursue a research opportunity later on. 270. It would be interesting if you could give us some indication of the number of training fellowships available in dentistry and the source of funding for them? Do any intercalated degrees exist or not?

(*Professor Brook*) Yes.

271. They do. Again numbers would be helpful, just approximately.

(*Professor Ashley*) The numbers, my Lord Chairman, are not that high as yet. At my own school we have had approximately 12 students each year since the course was extended reading intercalated BScs in a variety of subjects because everything is open to them from material science through psychology. We have got one this year studying health service management for a year.

272. I see.

(*Professor Ashley*) But the total numbers at the last count were approximately 36 each year. So one of the problems of this is funding. I think Scotland has a fairly generous policy to funding intercalated BScs but in this country, in England and Wales, and I presume Northern Ireland as well, it has to be funded largely by the student or the student's family or by whatever charity is prepared to give a scholarship. The MRC provides some scholarships but not very many. That is the major drawback especially with the increased amount of debt the students are getting into. I think this is a barrier to expansion of this particular very worthwhile development.

17 January 1995]

PROFESSOR W R E LAIRD, PROFESSOR F P ASHLEY,
PROFESSOR W HUME, PROFESSOR C SMITH AND
PROFESSOR A H BROOK

[Continued]

Lord Perry of Walton

273. The ratios of students doing dentistry first to the number of jobs as practising dentists and second to the number of jobs in the consultant area in dental hospitals, do these figures match those in medicine at all?

(*Professor Ashley*) No.

274. They do not, that is what I thought. The number of jobs you have got in dental hospitals is so small compared to that.

(*Professor Ashley*) Yes.

275. It is very difficult to see how you are going to get jobs for those who start training in the schools.

(*Professor Ashley*) The point is taken but I do not think we have yet reached a level where we have an adequate number of training opportunities. I was lucky in that I started off in my academic career doing full-time research on an industrial sponsored fellowship but that is the best way to start. We have not got enough opportunities yet so that all our junior people can actually start that way and many start, as has already been said, with very heavy clinical and training commitments. They are trying to develop research, go through training and so on and at the same time they have a heavy teaching programme. That sort of teaching would on the medical side be carried out largely by hospital funded staff. You do not see many junior lecturers in medicine.

Chairman

276. I understand that in Scotland the ACT component of funding for dental schools has been suspended and that is the comparable funding arrangement to SIFTR. Why do you think that is so? Is this because it has proved almost impossible to administer or what explanation do you believe one can give for that decision? Are you aware of that?

(*Professor Laird*) I was not aware it had been suspended. I would not know the reasons for it, my Lord Chairman.

277. You would prefer, would you, to rely upon SIFTR being adequately funded for the support of dental research?

(*Professor Laird*) That would be very helpful.

Lord Perry of Walton

278. I am bothered by the same ratios that we were just talking about but in fact to make any comparison with the medical side where 1.5 per cent of the NHS total expenditure is being said by the Government to be spent on research, I cannot see how it would work in the dental structure. Admittedly the £1.8 million plus the R of SIFTR is very small by comparison but there must be some figure in between that makes more sense and I do not know what it is.

(*Professor Laird*) Certainly, my Lord, £1.8 million we regard as rather low and we are not quite sure how Professor Johnson worked out his figures on that.

279. The MRC they say they spent £1.2 million and the Wellcome Trust £675,000 and adding those two together comes almost to the £1.8 million and that would be from outside sources, as it were, that does not include the R component of SIFTR.

(*Professor Laird*) We would be surprised if there was not a lot more money in the pool than that. We looked at the monies available at the last research assessment exercise and I think if I am quoting Professor Smith correctly over four years it was £20 million which is around about £5 million per annum of research money being generated by dentistry.

280. Where do you think that comes from outside?

(*Professor Laird*) Industry, charities, research councils obviously, NHS, local endowment schemes.

(*Professor Ashley*) You are referring to really NHS R&D presumably?

281. No, I am taking the total.

(*Professor Ashley*) Do you want to include the university Higher Education Funding Council R in there as well? If we are comparing it with medicine which I think, my Lord, you were doing, you were saying 1.5 per cent of the NHS spend should be on R&D, well then that does not include the university HEFC funding. So from that point of view I suppose that would be the other major component. I would have said we could certainly spend more on dental research and there would be a case for developing research in that way. One of the problems is that all these things are really inherited historically. SIFTR was set at the level of the dental hospitals' funding as at that time it was introduced.

282. So the extra money, the £5 million, is basically university contribution?

(*Professor Smith*) No, not the university contribution, my Lord. It is other sources of funding like toothpaste manufacturers, materials companies, the EEC, various other smaller charitable bodies.

Lord Gregson

283. Nuffield provides some, do they not?

(*Professor Smith*) No.

284. I know of one Nuffield grant.

(*Professor Smith*) Yes, they have provided funds in the past.

Baroness Perry of Southwark

285. The HEFCE component must be tens of millions, must it not?

(*Professor Smith*) Yes.

Lord Perry of Walton

286. If you are in fact spending about £5 million a year on research from these various sources, could you see the NHS contribution going up to £24 million? I ask that in all seriousness because it seems to me that it would be straining things a bit to expect to spend it usefully?

(*Professor Ashley*) If you think of what Culyer has said they should be providing in the post-Culyer market: you think of core facilities in which research can be carried out (which at the moment are entirely funded from the university side in all our dental hospitals and schools) and of course staff to allow that to happen, once again at the moment this is entirely funded from the university side. No hospital that I am aware of is having any input to these components. If the hospital side was picking up some of these costs it would release our university staff, take the pressure off them, and also release the

17 January 1995]

PROFESSOR W R E LAIRD, PROFESSOR F P ASHLEY,
PROFESSOR W HUME, PROFESSOR C SMITH AND
PROFESSOR A H BROOK

[Continued]

[Lord Perry of Walton *contd.*]

university budget to allow them to get more basic scientists in. We are under-funded on research on the university side too. The traditional split on the university side of our income is 80 per cent teaching and 20 per cent research. The medical school split is 65 per cent teaching and 35 per cent research. So I think the answer to your question is yes, given a properly planned period of expansion.

Lord Gregson

287. Could you give us some idea how much dentistry is carried out in hospitals which are not teaching hospitals and are therefore not covered by universities? There are hospitals which carry out dental work which are not attached to universities, are there not?

(*Professor Ashley*) There are no dental hospitals which are not supporting a dental school. Hospitals have departments of oral and maxillo-facial surgery and usually orthodontics and sometimes restorative dentistry.

288. Any idea what the proportion is?

(*Professor Ashley*) I think it is best to think in terms of the proportions of the workforce. Approximately 90 per cent of dentists work in general practice.

Chairman

289. You are suggesting about 10 per cent?

(*Professor Ashley*) No, 10 per cent are in dental hospitals and other hospitals.

290. I see. Are you including maxillo-facial surgery in dentistry?

(*Professor Ashley*) No. That is the figure we have been asked for an estimate for and I am looking to my colleagues hoping somebody will come up with a figure for the proportion. It is very difficult. Do you mean the proportion in manpower? I would put it at about half the number of consultants that there are in the dental hospitals. Do you think that is a reasonable estimate?

(*Professor Laird*) Yes.

291. So there are about half as many consultants in oral surgery—

(*Professor Ashley*)—and orthodontics in general hospitals.

292.—and orthodontics in hospitals which are not dental hospitals throughout the NHS?

(*Professor Ashley*) But they are mainly oral maxillo-facial surgeons and there is very little research activity associated with that.

(*Professor Hume*) I am not sure, my Lord Chairman, that that seems reasonable. If you look at the number of consultant oral maxillo-facial surgeons around the place the ratio of those working in DGHs to dental hospitals must be in the ratio of about 4:1.

(*Professor Ashley*) We can get that information, my Lord Chairman.

293. That would help, thank you. Is it still the case that practically all the people working in maxillo-facial surgery and oral surgery are jointly qualified medical and dental people?

(*Professor Brook*) Yes.

294. To clarify the point I raised before when I was talking about Scotland and ACT, it came from a paper which was produced for us by Professor Gainsford from King's College. It related to the third interim report of SGUMDER, the Steering Group on Undergraduate Medical and Dental Education and Research, and it is said, "... in Wales, the single dental hospital receives its total allocation as a block contract from the South Glamorgan Health Authority. In Scotland, funding arrangements have recently been revised following a review. For the three years commencing 1993-94, dental hospitals would be fully funded under central block contracts and dental ACT (the equivalent of SIFTR) would cease. The intention was to attempt, during this period, to assess dental undergraduate teaching costs, to allow subsequent contracting on the basis of actual costs ..." and separated from research. I thought I ought to raise that with you, so you can perhaps try and clarify it for us in subsequent correspondence.

(*Professor Ashley*) A similar development is taking place in England.

295. It is? So you think SIFTR may be under threat in this country in dentistry?

(*Professor Ashley*) Well, we may have something better, which may be central funding on a contract arrangement. The proposal is that we would have a contract to provide sufficient money to cover all our student activity where they are treating patients, and all our out-patient activity which is necessary for student treatment, in other words where they are in attendance. We would only contract for our in-patient activity and our day patients. That proposal is being considered at the moment and I understand it is on the Minister's desk, as it were.

296. But what about research?

(*Professor Ashley*) These proposals were floated before the Culyer Report was published, and I presume that would be a separate contract with our regional research and development person.

297. So perhaps you will consider that as being quite a separate thing from the present arrangement of SIFT?

(*Professor Smith*) The NHSME and the Department of Health are about to undertake an exercise with dental schools and hospitals to try and identify the R component in dental SIFTR.

298. That is helpful, thank you.

(*Professor Smith*) May I return to answer a question which Lord Perry asked earlier on the amount of funding which came from the NHS and local hospitals out of the nearly 20 million grants and contracts income which dental schools and hospitals identified in the last HEFC research assessment exercise? Just over 1.5 million of the 19 million came from the NHS, and that does not include the R component of Dental SIFTR.

Baroness Perry of Southwark

299. I wanted to pursue a point which Professor Ashley made about his own career, that he started his research activities funded by industry. I think it was in Professor Johnson's letter that there was mention

17 January 1995]

PROFESSOR W R E LAIRD, PROFESSOR F P ASHLEY,
PROFESSOR W HUME, PROFESSOR C SMITH AND
PROFESSOR A H BROOK

[Continued]

[Baroness Perry of Southwark *contd.*]

of the lack of a recognisable UK dental industry so to speak, an industry which might be a sensible source of funding; the dental equipment industry. Presumably there is an international dental equipment industry with whom you have links and from whom you get funding? Is there anything you can tell us about trying to tap that as a source of funding, making sensible links with it? Have you been successful in getting inward investment from other countries' dental equipment industries?

(*Professor Brook*) The links with industry have been with the dental equipment industry, which is very much the equipment used within surgeries, in the development of dental materials and also in oral health care products. I think in each of those fields there has been an attempt to make links. It is specifically in dental equipment that there are no major manufacturers within the UK at the moment but in the other fields there is more linkage. With the oral health care product manufacturers there have been considerable efforts to work with them, although some of these companies and the pharmaceutical industries have tended to take the view that rather than establish new units within dental schools (some which were established a long time ago have been maintained) they have wanted to place contracts where they felt they were getting value for money. They are open to approaches but they actually want to choose where to place the contracts. If you look around each of the dental schools, we have been increasingly successful in building up these contracts and there has gradually been more funding coming in that way, but it has not been always substantial.

300. What about inward investment from the international dental equipment industry? Have you been successful there too?

(*Professor Brook*) Not so much with the dental equipment industry, rather with the oral health care product development.

(*Professor Smith*) Between 1988 and 1992 three times as much money came into dental schools for research from industry than from the NHS.

Chairman

301. Thank you, that is helpful information. To follow up that point, there have been many sad stories about the medical equipment industry in that we no longer manufacture scanners in this country of the kind in which we were first in the field, we no longer manufacture electron microscopes, and Professor Johnson's memorandum suggests the British dental equipment industry has declined. Are there any success stories in this field? Where do you get your dental equipment from nowadays?

(*Professor Laird*) I think mostly we get our dental equipment from outside the United Kingdom. I can speak for my own school, we have re-equipped the whole clinic recently and it was bought from Finland.

302. Finland?

(*Professor Laird*) Yes. Germany is another heavy source of dental equipment.

303. Why is it that a once highly successful industry in this country has declined in the way it has?

(*Professor Laird*) I think it is purely a matter of the profit that the companies were able to make. Presumably the Finns can make the same equipment or similar equipment cheaper.

Lord Gregson

304. Did we ever really have a well established dental equipment industry in this country?

(*Professor Laird*) Yes I think we did have at one time. Quite a lot of dental supply companies existed in the country, many were taken over by outside bodies and many went bankrupt.

Chairman

305. What can you tell us about the October 1994 Advisory Group on Dentistry Report? Has it actually been published? What are your views about the outcome?

(*Professor Laird*) My Lord, we cannot tell you very much about it. It has been published—I have a copy of it with me—but it has not been widely circulated throughout the schools to have comment made on it. The principle of it being on primary care research and development, the principle seemed to be a very good one but as far as I am aware there has been no move forward to capitalise on it at this stage. Certainly some of my colleagues have indicated that the report has not been circulated widely.

306. Let us presume for a moment that the NHS were prepared to put money into research in primary care in dentistry, how could that be organised?

(*Professor Ashley*) The document gives ten priority areas and bids presumably would be invited under those headings.

307. Who would put in the bids? Would it be dental schools or dental hospitals in collaboration with practitioners in the field?

(*Professor Laird*) It may well be, my Lord. In my own area we have appointed a research director for general practice and that sort of primary care type of study might be quite appropriate to be done linked with the school.

308. Do you have many dental practitioners in the community holding honorary appointments in your dental schools to provide a kind of link with the community?

(*Professor Laird*) Yes, I think most of us have a substantial number of them.

(*Professor Ashley*) Not honorary appointments, my Lord Chairman, many of them come in and teach for one day a week.

309. Sessional appointments?

(*Professor Ashley*) Yes.

310. Funded by the school?

(*Professor Ashley*) Or hospitals.

Lord Gregson

311. Are there not also appointments in non teaching hospitals by primary dentists carrying out dental work?

(*Professor Ashley*) There are some clinical assistant type posts in the hospitals that have consultants in oral medicine, maxillo-facial surgery and so on. They

17 January 1995]

PROFESSOR W R E LAIRD, PROFESSOR F P ASHLEY,
PROFESSOR W HUME, PROFESSOR C SMITH AND
PROFESSOR A H BROOK

[Continued]

[Lord Gregson *contd.*]

would tend to be treating medically compromised patients under the supervision of the consultant.

Lord Perry of Walton

312. Can I get some idea of numbers? I think you said at your school there were 29 consultant posts?

(*Professor Hume*) No, not at all, Sir, 29 university academics covering ten clinical disciplines plus a range of pre-clinical disciplines. The number of consultants is something like 20, of whom I think 12 are clinical academics and only eight NHS appointees.

313. Would that be an approximate average for the other dental schools?

(*Professor Ashley*) Some of us are bigger. This is all related to student intake and I think this is a very important point. Because there are fewer dental students in the country, even though there are fewer dental schools, we tend to be smaller than our sister medical schools. I have an intake of 88 students a year and we are by far the largest school. My sister medical school has an intake of 200 medical students. Now that in itself will support a much larger staffing. Our medical school is much bigger than we are and if you have a larger staff you have more staff in each department, you cannot say "I will not teach dental radiology or I will not teach this". You have to teach all these subjects. We start off at a disadvantage because of that. It is even greater if the size of a dental school is 50.

(*Professor Smith*) That is the smallest, the average would be about 60.

Earl of Selborne

314. Chairman, is this not a rather dangerous argument. Would this not lead to an argument of reducing from 13 to a lower figure the number of dental schools?

(*Professor Ashley*) There are other considerations, here. Dental schools and hospitals have other roles than undergraduate education. That is a primary role but they also act as a centre of excellence in the region they are in for dentistry and they have a major postgraduate role there. They have their specialist role. The specialist departments you find in a dental hospital do not exist in general hospitals. If you suddenly said: "Right we will only have two dental schools in the country" to get critical mass, you would have a terrible effect on the provision of dental care in the country.

Lord Perry of Walton

315. If I could follow that up: that would make, by my mental arithmetic, about 800 altogether in the 13 dental schools and you said another 50 per cent of that would be in other teaching hospitals, putting it up to 1200?

(*Professor Ashley*) No.

316. I am lost!

(*Professor Ashley*) I was talking student numbers, student intake with my figures 88 and 60.

317. I was talking staff.

(*Professor Ashley*) No. The student intake determines your funding and determines your staff structure.

Chairman

318. To clarify that staff point, you said 29 academic appointments at your school and about 20 consultants?

(*Professor Hume*) Including NHS consultants.

319. Including NHS consultants. But presumably under the knock for knock agreement there is no money actually changing hands. Presumably the clinical services given by your 29 academics do not require any money to be passed from the university to the NHS?

(*Professor Hume*) The services that are provided by the clinical academic have been considered by part of NHSE to be distorting the market.

320. The knock for knock agreement?

(*Professor Hume*) Yes.

321. Because you see in university pathology departments by contrast they are often jointly funded. Half the costs of the university professors and lecturers in pathology are paid by the NHS for services they give. It is the only example I know of. You do not have such an example in dentistry?

(*Professor Ashley*) My Lord Chairman, we do.

(*Professor Laird*) We have some staff who are funded by the NHS but employed by the university and have contracts with the university.

Lord Gregson

322. Can I go back to the question the Chairman asked about research into primary dental care. You say you would respond with bids but who would construct the programme? That is what I do not understand really. There is not a central dental research body within the NHS which sits as a council and says: "This is what we want to do", is there, other than the Medical Research Council?

(*Professor Ashley*) My Lord Chairman, this is what has happened. This has been set up and with this document, which was referred to before, there has been a process where areas have been prioritised and this has been published.

323. Under a central body?

(*Professor Smith*) I believe the process is that this publication now goes to the Director of NHS R&D and the central committee and they will decide what bids they wish to ask for from the general community of dentistry. As you have heard most of the bids might be expected to come from dental schools because that is where the focus of dental expertise is. I would only add into that I suspect many of the dental schools would liaise closely with other departments within the universities that were involved in health care research and health services research in order to put forward a viable bid.

324. I can see that, but what I cannot see is anybody on the staff of the Director of NHS Research who is in fact a dentist.

(*Professor Ashley*) Nor can we.

17 January 1995]

PROFESSOR W R E LAIRD, PROFESSOR F P ASHLEY,
 PROFESSOR W HUME, PROFESSOR C SMITH AND
 PROFESSOR A H BROOK

[Continued]

[Lord Gregson *contd.*]

(*Professor Laird*) That is a concern of ours, my Lord.

Chairman

325. There is a possibility, is there not, that you together with a group of community care dentists giving dental services to the community could put together a research grant application which would go to the Regional Research Committee under the locally operated Regional Research Scheme? So presumably on the regional body there is a dental representative, is there?

(*Professor Ashley*) We can put in applications to the Regional R&D Committee as a dental school and hospital—we have just been successful in getting one approved—because we are providing a lot of care for patients within our own environment. In my own region there is a dentist on the panel, but I do not think that is universal.

Lord Gregson] What happens when the regions disappear?

326. It is therefore possible that these priorities determined by a Central Research and Development Committee might be fulfilled by allocating funds for these priorities to the Regional Directors of R&D who would then be required, in consultation with the dental hospital and community dentists, to perhaps commission research or seek bids for research? Is that possible?

(*Professor Ashley*) Yes.

327. Are there any incentives for primary care practitioners to do research at the moment?

(*Professor Ashley*) Self-fulfilment.

328. Is it therefore possible that under such a grant from a regional body, a primary care practitioner might be funded for a session to enable him or her to undertake research?

(*Professor Ashley*) That is possible.

329. Is that one you would favour?

(*Professor Laird*) That is one I would personally favour, certainly.

Earl of Selborne

330. I would like to come back to the issue we have been discussing in general throughout the morning, and that is the scale of the notional pot of gold you referred to. We recognise that it is funded in large measure from the Funding Council, from SIFTR, from MRC, from the Wellcome Trust, but throughout the morning we have been told there is a strong feeling the size of that pot compares unfavourably with other medical research. That may well be right, but is that in itself a case for increasing the size of the pot? How else do you measure the feeling of disadvantage? It may be that you are not pulling your weight internationally or you are not contributing as an international community to the body of scientific research work in dentistry that you should be, although the evidence we have been given suggests you are doing rather well in that respect. Is it sufficient to base your case for increasing the size of the pot of gold simply by saying that your colleagues in medicine are doing better?

(*Professor Laird*) I think the first thing is that it is important to realise that dentistry from the point of view of achieving grants is not as successful as medicine. Dentistry does not have the same emotive effect on the general public. People do not die of dental disease, indeed there is a perception that dental disease has been defeated, which is an incorrect perception. These sort of factors do influence the lack of money which is available for dentistry. You ask why should we get more money. It is very frustrating when a colleague submits a grant application to the MRC which is given an alpha rating but which is not funded. That is the sort of problem we are up against. If the MRC gives it an alpha rating then surely it is worthwhile research but there is not the money there to fund it. That is why we want the pot of gold safeguarded and that is indeed why we want the pot of gold increased for dentistry.

331. I think other areas sometimes fail to get funded for a project.

(*Professor Smith*) May I also attempt an answer to your question in that the international comparison which is being made is within the field of dentistry. It shows that United Kingdom dental research stands up well in the international dental research activity. When you compare dental research in this country with other areas of research within the university sector we do not come out too well. One of the reasons for that is the 80 per cent to 20 per cent teaching to research split in the initial funding that provides a main core funding from the HEFCE. If we could achieve a higher proportion of research funding from that quarter, that would enable us to increase the number of academic appointments within our dental schools and generate more research activity and make us more comparable with other disciplines within the university sector.

Chairman

332. It then just follows that we should ask you just for a moment or two about the future of MRC involvement in research and research training in dentistry. Should they not be asked to take into account, for example, the lack of funding from charities which, of course, now in medical research provide more money than the MRC does, though of course the Wellcome Trust is giving you some priority, is it not? What is your view about this?

(*Professor Smith*) Between 1988 and 1992 the charities actually provided more dental research money than the ABRC group.

333. They did?

(*Professor Smith*) Yes.

334. From which charities then did you obtain most of your research funding, Wellcome and who else?

(*Professor Smith*) Cancer Research Campaign.

(*Professor Ashley*) Arthritis Council, lots of charities.

(*Professor Smith*) Some from the Oral and Dental Research Trust.

335. Do you get much support from other Government departments? I seem to remember years ago in the dental school when I was working in

17 January 1995]

PROFESSOR W R E LAIRD, PROFESSOR F P ASHLEY,
 PROFESSOR W HUME, PROFESSOR C SMITH AND
 PROFESSOR A H BROOK

[Continued]

[Chairman *contd.*]

Newcastle somebody had a grant there for some kind of adhesive which was being used in dental research but which was also being used by the Ministry of Defence for limpet mines. Is there anything comparable?

(*Professor Brook*) Certainly, my Lord Chairman, there has been the return back from research in dental materials that has then gone on into medicine in bone cements.

Lord Gregson

336. When I was a member of the Science and Engineering Research Council the Materials Sub-Committee provided grants for dental material research quite separately from the Medical Research Council.

(*Professor Ashley*) That is still the case.

Chairman

337. There are a good many sources other than NHS and the MRC to which you can apply?

(*Professor Smith*) The amounts tend to be small.

338. I know. Thank you. Are there any additional points you would like to raise?

(*Professor Brook*) There was the question of collaboration with medical schools in research and the degree to which that was occurring. This varies from one school to another but there are indeed research groups that are common across the whole of a medical college which will include members of the dental schools. Sometimes we find that in fact there are dental members leading those research groups, for example in bone tooth and biomaterials research. There are clear examples we could cite, there are certain outstanding individuals and collaboration is occurring. I think we wanted to emphasise too that collaboration is occurring outside medicine; we have already alluded to areas like materials research but in many other areas too, such as social science.

339. Any other questions?

(*Professor Laird*) Nothing more, my Lord.

Chairman] Thank you very much for coming and for the evidence which you have given to us.

Letter from Professor NW Johnson, King's College London

I write as one long experienced in dental research in the United Kingdom and abroad to ask that their Lordships give attention to the following matters in the assessment of NHS reforms and the Culyer Committee on medical and dental research in the United Kingdom.

1. Underfunding. Research into matters dealing with oral and dental health is, I have estimated from various sources, currently funded in the United Kingdom to approximately £1.8 million per annum. This is a tiny proportion of the cost of NHS dentistry which totals £1,600 million per annum in the General Dental Services alone. This is at least an order of magnitude less than the 1.5 per cent of NHS expenditure targeted for R&D within the NHS as a whole. Application of the same formula to dental research would revolutionise the UK scene.

2. Dental research in the United Kingdom enjoys a high national and international reputation for quality. However its volume is declining as is its influence, in line with the general decline in British science as a result of declining R&D expenditure from all sources. There is time to reverse the trend.

3. Most of this research is done in Universities with dental teaching schools. An adequate floor of support is essential for the research base to be maintained. The R contribution of SIFTR has been inadequate in the past. The Culyer report provides an opportunity to put this right but this is only likely to happen if there is adequate representation of academic dentistry on the decision making pathways.

4. There needs to a cultural shift in the United Kingdom which recognises the importance of oral health research and generates an adequate career structure for those who wish to dedicate their lives to it. This needs input from the health departments, the higher education funding councils, the research councils and medical charities. At the present time academic staff in dental institutions are far too heavily committed to teaching and the supervision of under-graduate students to provide adequate time for research. There also needs to be improved training and education for the researchers.

5. Their Lordships might like to start a dialogue with the Department of Trade and Industry over the difficulties created by the lack of a manufacturing base for dental materials and equipment in the UK—sadly an area in which British industry was once strong. The fostering of links between industry and academia could be beneficial; major international oral health care companies want this and the DTI could perhaps help.

17 January 1995]

[Continued

I should be happy to provide more detailed evidence if their Lordships please.

Professor N W Johnson

Nuffield Research Professor of Dental Sciences at the Royal College of Surgeons of England. Director of Research and University Post-Graduate Education, King's Dental Institute. Professor of Oral Pathology—University of London

29 December 1994

Letter from Dr Grant Lewison, Policy Analyst, PRISM, The Wellcome Trust

I received a telephone call from your colleague, Ms Jane Sanders, on Tuesday afternoon. She requested information on the support by the Wellcome Trust for dentistry research in the UK in order to brief your Committee for their meeting next Tuesday. From our Grants Database, it appears that our current annual expenditure on dentistry research is approx. £675,000, based on the values of current grants divided by their duration in years. The distribution of funds between the different centres is approximately as follows:

Centre	Spend, £ k	Centre	Spend, £ k
Univ Coll, London	90	Manchester	87
Bristol	75	Sheffield	75
UMDS	62	Liverpool	61
Kings Coll, London	37	Southampton	31
Leeds	29	London Hospital	26
Kings Coll Hospital	21	Overseas	78

I attach a list of the individual current grants so that you can see the subjects covered (*not printed*).

Your committee may also be interested to see the results of a small bibliometric analysis of publications in the field of dentistry. The analysis was performed on the *Science Citation Index* for the years 1988 to 1994 (Jan to Sept) and included articles, notes and reviews only. The field of dentistry was defined by means of a list of specialist journals (all of whose publications were included) and specialist title key-words, so that any papers in other journals were included if they had one or more of such key-words in their titles. (Non-English titles are all translated into English for the *SCI*.) The total numbers of papers, and the numbers with an address in the UK, in each year were as follows:

Year	World	UK	Percent
1988	3,260	454	13.9
1989	3,479	478	13.7
1990	3,423	486	14.2
1991	3,623	457	12.6
1992	3,691	505	13.7
1993	3,595	473	13.2
1994 (i-ix)	2,595	343	13.2

There is a modest growth (2.4 per cent annual average between 1988–90 and 1991–93) in the world output, as recorded in the *SCI*. The UK share is declining somewhat but the numbers of UK papers are approximately constant over the period. Since the average UK share of world biomedical papers in all fields is about 9–10 per cent, this suggests that UK relative performance in dentistry is rather high compared to other biomedical fields.

I have also looked at the centres of dentistry research in the UK, and compared the outputs in 1988–89 with those from 1993–94. The following table shows the numbers of addresses in each city during the two two-year periods expressed as a percentage of the total numbers of UK papers. Because of co-authorships between institutions, the percentages sum to more than 100. The cities are ordered by their rank in the later period.

City/code	1988–89, %	1993–94, %
London	38.5	43.5
of which		
WC	14.3	12.7
SE	11.5	12.5
E	5.9	6.6
Other	2.7	3.2
Unclassified	3.3	7.8
Bristol	9.4	12.1
Manchester	12.7	11.8
Glasgow	10.8	10.2
Newcastle/Tyne	9.7	10.0
Cardiff	10.6	6.7
Dundee	4.9	6.0
Leeds	5.8	5.6

*17 January 1995]**[Continued]*

<i>City/code</i>	<i>1988–89, %</i>	<i>1993–94, %</i>
Sheffield	5.4	5.5
Birmingham	11.5	5.1
Edinburgh	3.6	4.8
Liverpool	5.6	4.3
Belfast	1.2	3.7
Oxford	1.3	2.1
Cambridge	0.6	2.0

There are several interesting features about this table. It shows the dominant (and increasing) position of London, particularly UCL (WC) and Kings College and UMDS (SE). Oxford and Cambridge, which dominate many other fields of biomedicine, are minor players in dentistry. There are some notable changes in relative standing among other cities—Bristol and Belfast have risen, and Birmingham and Cardiff have gone down.

13 January 1995

MINUTES OF EVIDENCE
TAKEN BEFORE

**THE SELECT COMMITTEE ON SCIENCE
AND TECHNOLOGY**

**SUB-COMMITTEE I MEDICAL RESEARCH AND
THE NHS REFORMS**

Tuesday 24 January 1995

THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

Professor Denis Pereira Gray OBE MA FRCGP, Dr William McN Styles OBE MA FRCGP, Professor Roger Jones MA DM FRCP FRCGP, Dr Andrew Farmer MA MRCGP and Dr Kieran Sweeney MA MRCGP

Printed pursuant to the Order of The House of Lords of 22nd November 1994

LONDON : HMSO

£8.75 net

TUESDAY 24 JANUARY 1995

Present:

Butterfield, L.
Gregson, L.
Nathan, L.

Perry of Walton, L.
Walton of Detchant, L.
(Chairman)

Memorandum by the Royal College of General Practitioners

The Royal College of General Practitioners thanks the Select Committee on Science and Technology, of the House of Lords, for the invitation to give evidence on medical research and the NHS reforms and accepts with pleasure. The College is also grateful to have been asked to give oral evidence and is doing so through its Research Network.

THE ROLE OF THE RCGP IN RESEARCH IN GENERAL PRACTICE

The Royal College of General Practitioners was established in 1952. It was formed following a Steering Group whose report indicated the importance of research in general practice, and the College since its earliest days, has always valued research in general practice and worked to support it. There has been a Research Committee/Division/Network since the College was started.

The twelve principal research achievements of the College have been:

(1) VALUING GENERAL PRACTICE RESEARCH

This was an immediate priority and the first College Council chose as the first President of the College, Dr William Pickles, the outstanding general practitioner research worker of the time (Pickles, 1939).

The College has consistently valued, honoured and encouraged general practice research. Several Presidents such as Dr Ian Watson, and Professors Byrne and Drury have made notable research contributions to the literature.

One other College figure made exceptional research contributions, Dr John Fry, who was a member of the College Council for longer than anyone else before or since, and was probably the best known general practitioner research worker in the world (*The Times*, 1994). The College has introduced research prizes and awards and later, research training fellowships.

(2) SCIENTIFIC JOURNAL OF RECORD

One of the RCGP's main contributions to research in general practice was the creation of the first scientific journal of general practice in the world. The College established its own journal in 1958. By 1961 it was the first general practitioner journal to be included in *Index Medicus* and it now holds the leading place in the USA *Science Citation Index* (1991) of all general practice journals. It is ranked 19th among all the general medical journals. The College developed and still pays for this journal not just as a service to College members, or for British medicine, but as the leading scientific journal in the discipline of general practice in the world.

(3) COLLEGE RESEARCH UNITS

Early in its history the College established a number of research units built around its early research leaders. Two of these continue in 1995: the Birmingham Research Unit and the Manchester Research Unit of the College.

These were among the very first research organisations in general practice in the UK. Before they existed, general practitioners had to do their research work alone in their practices or join university departments in other disciplines.

The Birmingham Unit was master-minded by Dr Donald Crombie who made an immense personal and unit contribution to the development of general practice as a discipline. The Birmingham Unit established what are now the series of national morbidity surveys in conjunction with both the Office of Population Censuses and Surveys and the Department of Health (RCGP et al, 1982). It also pioneered through practice activity analysis early forms of medical audit. It is best known for its work in monitoring influenza. This Unit is now directed by Dr Douglas Fleming, who has published extensively, for example on European referral rates.

*24 January 1995]**[Continued]*

The Manchester Research Unit was established by Dr Clifford Kay, who created the oral contraception study, a survey, of 23,000 women on the Pill and 23,000 controls. This is one of the largest surveys in the world and an invaluable source of information on the good and bad effects of the Pill.

This Unit has also published on such topics as the sequelae of abortion and is currently involved with examining the implications of the use of clot busting drugs by general practitioners. It is currently directed by Dr Philip Hannaford.

(4) FUNDING GENERAL PRACTICE RESEARCH

The College has campaigned for funds to establish an independent Scientific Foundation Board, with capital of over £1 million, the interest from which is devoted to funding general practice research. This Foundation is now the largest charitable foundation which devotes its funds exclusively for general practice research. It is currently chaired by Professor David Morrell.

(5) GENERAL PRACTITIONERS ON THE STAFF OF THE UNIVERSITIES

The College pressed for general practitioners to be appointed to the staff of universities and later pressed for chairs of general practice.

There are now departments of general practice in every medical school and chairs in all except Oxford and Cambridge. A large number of the earliest chairs including the first chair of general practice in the world, the first chair of general practice in England, the first chair of general practice in Ireland, one of the leading chairs in general practice in Canada, and the first chair of general practice in a postgraduate department of general practice were all taken by members of the Council of the College (Pereira Gray, 1992).

(6) REPRESENTATION

The College, as a medical Royal College, has representation on many national organisations and its representatives continually seek to advance the cause of research in and on general practice and by general practitioners.

(7) MEDICINES SURVEILLANCE

The RCGP has established a wholly owned company (The Medicines Surveillance Organisation) for the purpose of carrying out surveillance of drug safety in the NHS. Clearly general practitioners are the principal prescribers and as patients remain registered with general practitioners for as long as 12 years on average, general practice is the natural site to monitor drug use and safety and to establish long-term results and adverse effects.

(8) RESEARCH ETHICS

There are some special issues about the ethics of research and there are particular advantages in having a central research ethics committee.

The RCGP has had its own Research Ethics Committee for several years and this is currently chaired by Professor Sir Michael Drury.

(9) MRCGP EXAMINATION

The MRCGP examination is the entry route to membership of the College. It was introduced in 1965 and is taken by about 2,000 doctors each year. Recently it introduced a compulsory examination paper requiring candidates to assess critically a research publication as a way of increasing research assessment skills among general practitioners. The current Convenor of the Examiners is Professor Lesley Southgate.

(10) CONFERENCE OF ACADEMIC ORGANISATIONS IN GENERAL PRACTICE

The RCGP established and services this Conference and also principally financed its recent publication (CAOGP, 1994).

(11) FELLOWSHIP BY ASSESSMENT

In 1989 the RCGP introduced the most rigorous quality assurance programme in general practice in the British Isles. Although this is not specifically a research development it is certainly aimed at improving the quality of care provided in general practice and it requires the achievement of high quality information in the practice of the applicant (RCGP, 1990a). Two of the first 43 Fellows by Assessment hold a second degree (one MD).

24 January 1995]

[Continued]

The College has adopted a formal target of 250 Fellows by Assessment by 1996 and sees this process as a preliminary to some of these general practitioners going on to undertake research theses. Some College members are already working for both Fellowship by Assessment and a research thesis.

By the end of this decade the RCGP foresees general practitioners with both MD/PhD or MPhil and FRCGP by Assessment.

(12) RESEARCH GENERAL PRACTICES

There has never been an organisational equivalent in general practice to the teaching hospitals, so the College has set out to create one. A new idea (Pereira Gray, 1991) has been the establishment of RCPG research general practices funded not for a project, but as a deliberate attempt to cover the infrastructure costs and the experimental phase of "pre-protocol research" which by definition is never project funded. The Association of University Departments of General Practice has developed a very similar concept called "designated academic practices".

The first two RCGP practices were appointed in 1994 and the College hopes to advertise several each year. The RCGP has been particularly encouraged by the NHS R & D Directorate in the South and West region which has adopted this idea and which has, at the time of writing, advertised for research practices in the South and West, offering £12,500 pa for three years.

CURRENT RCGP RESEARCH PRIORITIES

The Royal College of General Practitioners has five current research priorities:

- (1) To promote a culture of research in general practice
- (2) To establish research general practices
- (3) To establish as many research training fellowships as possible for general practitioners
- (4) To encourage and support doctoral theses from general practice
- (5) To foster an alliance among the academic organisations of general practice

The Royal College of General Practitioners will continue to maintain a major interest in research in general practice/primary care.

BACKGROUND—NHS

In the NHS there is some overlap in the terms "primary care" and "general practice". Primary care strictly defined includes accident and emergency departments and genito-urinary medicine clinics as well as some clinics in the community such as family planning. However, the vast majority of primary care takes place in general practice which is the organisational focus for primary care in the NHS.

Furthermore, even for care like family planning, statistics from the Department of Health (1993a) show a ten year trend of rising proportions of patients using general practice. The College therefore believes that general practice is the natural focus for primary care which will be increasingly delivered in the future by a multi-professional primary health care team.

Responsibility

In the NHS in the UK there are only two categories of doctor who hold unsupervised responsibility for patients: consultants and general practitioners.

Numbers

General practitioners are not only numerically the largest branch of the medical profession, but in their highest grade, of principal in the NHS, they are about twice as numerous as all consultants in all specialties combined. The Secretaries of State (1986) wrote that about 90 per cent of all contacts between the population and the NHS takes place in general practice.

Organisational trends in the NHS

For several different reasons the role and responsibilities of general practitioners in the NHS have been and are continuing to increase. The NHS reforms have sharply increased the central role of general practice for the following reasons:

(1) INCREASED VOLUME OF CARE IN GENERAL PRACTICE

More comprehensive training and better support for primary care means that most common chronic disease is no longer referred to hospital. Over 90 per cent of all patients with anxiety, asthma, chest infections, depression, eczema, hyperlipidaemia and hypertension are not referred to hospital and are managed in general practice.

24 January 1995]

[Continued

Systematic screening of populations means that as many as ten per cent of the whole population can have a diagnosis of depression, eight per cent of asthma, six per cent with hypertension, six per cent with hyperlipidaemia, all at once in the same practice population.

On any day of the year over 95 per cent of the most medically vulnerable patients, ie those aged over 75, are at home in the care of general practitioners.

(2) DAY CARE SURGERY

Day care surgery is increasing rapidly. This means that patients come home to the care of the general practitioner the same night.

(3) EARLY DISCHARGE

Hospitals are discharging home both medical and surgical patients ever earlier. Convalescent home use after hospital admission has virtually disappeared. The duration of stay in NHS hospitals has roughly halved and continues to fall. Thus more and more of the work and responsibility for those patients is moving to general practice.

(4) CLOSURE OF THE MENTAL HOSPITALS

The policy of progressively closing mental hospitals is steadily developing. In some districts, for example Exeter, two mental hospitals have been closed. Whilst the policy of implementing community care is supported, the responsibility for general practitioners has increased greatly and these patients have great needs and high consultation rates.

(5) PATIENT REQUEST AND DEMAND

The population is rightly better informed than ever before and is being systematically informed through general practice itself, television and the media, patient societies, and NHS authorities and policies such as the Patients' Charter.

All this requires primary health care teams not only to be better trained themselves, but to have increasing communication skills.

The Office of Population Censuses and Surveys (1991 in the *General Household Survey*) has shown that the consultation rate for all children in the UK has roughly doubled since 1972 from an average of four consultations per year to the current eight per year. A British baby now sees a general practitioner on average every six and half weeks.

Furthermore, some of the most demanding work is increasing. Salisbury (1993) showed that night calls are increasing at a rate of about ten per cent a year in the NHS.

(6) NHS POLICY

Finally, and very recently, whilst this paper was being prepared the NHS executive (1994) published a paper subtitled "A primary care led NHS" (cover enclosed as Appendix 1).

Lead responsibility of the whole NHS is now planned for primary care. Logically the research focus should follow.

Conclusion

The RCGP submits that the role and responsibilities of general practitioners have risen and are continuing to rise in the NHS and therefore that the research base of general practice and the amount of research which should be undertaken in general practice and by general practitioners should increase.

NEEDS BASED NHS

The funding of the NHS is based on two principles: numbers and need. Ever since the RAWP Working Party report (1976) there has been a debate in the NHS on how to calculate numbers and need in some manageable formula. The main conclusion has been various forms of weighted capitation. Regions and health commissions and authorities in the NHS are funded on this basis.

It is logical to apply these two principles of numbers and need to the research base of general practice. On both parameters general practice should now clearly take priority: first it is, as shown above, far and away the largest branch of the medical profession and secondly, among all the branches of medicine it is the one where research training has in the past been least developed.

Furthermore, the Health Service is driven by patients who come through the door of the general practitioner at an average rate of between three and four times a year per patient.

24 January 1995]

[Continued

As the challenge of effective and efficient purchasing in the NHS develops, so the research question of what exactly are the needs of patients registered with general practice, grows. General practice teams who know the patients personally, see them face to face, and visit their homes, are best placed to research this question.

Researching needs is likely to become more important than researching activity in the NHS.

Conclusion

The research priority for the NHS must now logically be a training programme for general practitioners and members of primary health care teams and research support for these staff.

RECOMMENDATION: THAT GENERAL PRACTICE SHOULD NOW RECEIVE THE HIGHEST PRIORITY FOR RESEARCH DEVELOPMENT

QUESTION 1 ASSESSMENT OF THE NHS R&D STRATEGY

The College is asked to comment on the NHS R & D Strategy.

First the RCGP wishes to acknowledge the importance of the earlier report from the House of Lords Select Committee on Science and Technology (1988) *Priorities in Medical Research*. This was most timely and its main conclusion that urgent action and reform of the arrangements for research in the NHS was then needed, was undoubtedly correct.

That report initiated the substantial changes in NHS arrangements and the RCGP acknowledges that crucial stimulus and thanks the House of Lords for it.

Professor Peckham and his colleagues have achieved three main targets already, first he has successfully raised the profile for research in the NHS. Secondly, he has advised and the Secretary of State for Health has accepted, the target of spending of 1.5 per cent of the total NHS budget on research and development. Thirdly, he has established a national organisation, represented in every part of the UK, devoted to R & D. The College warmly welcomes all this.

The RCGP has admired the considerable developments achieved by the Director of Research for the NHS, Professor Michael Peckham, his central advisory committee, and his NHS staff.

The College appreciates the immense challenge which he faced and generally supports the document *Research for Health* (Department of Health, 1993b), which he produced, and welcomed the invitation to attend when it was launched.

The RCGP also welcomes the establishment of both the Cochrane and York centres. It has visited the Cochrane Centre at Oxford and believes that rigorous analysis of the literature to establish and disseminate the message of research findings is logical, needed, and should be supported.

The York approach, especially its emphasis on health economics and the rigorous review of the quality of research evidence, is timely and also welcome.

However, much of what has been achieved has been focused on secondary care and general practice has not yet been given the research attention the College thinks it deserves.

Review for the future

The RCGP is clear that this is a particularly good time to review the R & D programme, especially since whilst this paper was being written the Secretary of State for Health announced, in December 1994, that she was accepting the main principles of the Culyer report (1994).

The main recommendation which the RCGP now makes for the future is that previous and current R & D thinking does not place enough emphasis on the main implication of current NHS policy especially with regard to "A primary care led NHS" (NHS Executive, 1994).

Computers

British general practice is relatively advanced in the uptake of computers. About 80 per cent of general practitioners use them significantly in their work. This is more than is the case for general practice in most other European countries or the rate of use in the hospital service.

This introduction of computing fits exceptionally well with one of the key strengths of British general practice, the registered list. This enables outcome studies to be more easily mounted as well as enabling accurate uptake figures to be derived for all services, both preventive and curative.

Such computer use makes this a good time for a national drive to strengthen the research base in primary care.

The College, having pioneered large research studies using multi practices and having been involved in the successive national morbidity surveys, is now keenly interested in pursuing their future potential.

24 January 1995][Continued

Primary care teams

The evolution of the multiprofessional primary health care team consisting of general practitioners, practice nurses, district nurses, health visitors, and increasingly physiotherapists and counsellors has greatly strengthened general practice. It means that in the future the research training programmes will need to be offered on a multi-disciplinary basis. At present the doctors in these teams are usually the only graduates. This will change as the nursing profession and the professions allied to medicine seek graduate qualifications and then research training for themselves as well.

As a first step the College wishes to give recognition to the considerable achievements of research by general practitioners often without support and almost despite the system. British general practice research with the Dutch and North American stands particularly well in the world.

Obstacles to research in general practice/primary care

The main obstacles to general practice research have been described in the British Medical Journal (Pereira Gray, 1991) and this is enclosed as Appendix 2.

The College believes that the Select Committee could now make an important intervention if it felt able in its report to concentrate on a small number of key changes which could make a substantial difference in taking the national NHS research strategy forward.

The College sets these out in the form of recommendations to the Select Committee and hopes that the Select Committee will itself be prepared to adopt and endorse them. They are included in the text as recommendations and repeated in summary at the end of the paper.

RECOMMENDATION: THAT SINCE THE NHS IS NOW TO BE PRIMARY CARE LED THE NHS RESEARCH STRATEGY SHOULD BE THE SAME.

Research general practices

There is an urgent need to establish for general practice some organisational equivalent of the teaching hospital in which NHS resources are channelled to support research.

The College offers the model of the research general practice as developed in the College itself and also in the South and West region as one useful model worthy of wider introduction.

RECOMMENDATION: THAT NHS FUNDED RESEARCH GENERAL PRACTICES SHOULD BE ESTABLISHED IN ALL NHS REGIONS

Research training fellowships

One of the biggest blocks to research in general practice/primary care is the lack of research skills, and the single biggest reason for this is the lack of opportunities for research training.

The reasons are mainly historical, in that when the medical profession was unified in 1858, the hospital system was developing quickly and the fast emerging teaching hospitals became associated with specialist practice. Although world class medical research had been undertaken before in general practice by Jenner in the eighteenth century, by Budd (1873) in the nineteenth century, and Mackenzie (1916) in the early twentieth century, no organisational focus for general practice research emerged until the College of General Practitioners was established in 1952. But by then the NHS had been introduced in 1948 and the research institutions were intimately interlocked with the numerous systems for specialist medicine and specialist training.

The most important of these are protected NHS funded training for all senior registrars, research posts funded at the rate of about one per every two NHS consultants, numerous research training posts funded by the Medical Research Council (MRC) and the charities, and a system of postdoctoral research development.

PROTECTED TIME FOR RESEARCH TRAINING

There are 3,875 senior registrars in the UK (Department of Health, 1994). Each of these is entitled to a day a week funded by the NHS to acquire deeper understanding of the speciality. They are expected to acquire research skills and training in research methodology and attend numerous courses, funded by the NHS to do so. Substantial numbers work for and acquire a higher university degree by research such as an MPhil, MD/PhD, or MS.

The main NHS support is, however, through the protection of time. Two sessions per week protected over some years for a senior registrar amounts to the equivalent of over 750 full-time posts funded each year by the NHS for specialist medicine. The NHS also pays for registrar committees to oversee these posts and to ensure that the time is really made available.

24 January 1995]

[Continued

RECOMMENDATION: THAT THE OPPORTUNITIES FOR OBTAINING RESEARCH TRAINING FUNDED BY THE NHS SHOULD BE PROGRESSIVELY EQUALISED BETWEEN PRIMARY AND SECONDARY CARE

Research training fellowships for general practitioners

The main proposal of the Royal College of General Practitioners is that a group of research training fellowships be introduced for general practitioner trainees and for general practitioners.

(A) POST-VOCATIONAL TRAINING

At present although general practice recruits some of the brightest young doctors in Britain there are no research training posts to offer them immediately after they complete the trainee year.

The College commends the development at the Southampton Medical School where Professor Anne Louise Kinmonth with support from the Nuffield Provincial Hospitals Trust has pioneered a two year part-time traineeship with research training built in.

Associate academic practitioners have been developed through tasked money at Leicester, Cardiff, and Edinburgh and have great potential.

RECOMMENDATION: THAT AT LEAST 12 RESEARCH TRAINING PLACES BE MADE AVAILABLE IN EACH NHS REGION AFTER THE SATISFACTORY COMPLETION OF VOCATIONAL TRAINING

(B) FOR GENERAL PRACTITIONER PRINCIPALS

In addition there is a great need for those general practitioners who are already holding principal posts. They may enter these as early as age 28 although 30 is more usual. Since they have been deprived of research training beforehand they may often find that their interest in research awakes during their work as a principal.

The College sees an urgent need for research training positions both full time and part time in all parts of the UK. The aim is to provide protected time so that general practitioners can leave their practices to acquire additional research skills and a research degree (MPhil, PhD, or MD).

The College has itself been offering some part-time research training fellowships for several years. It has been impressed with how many of these have led to general practitioners acquiring MDs and a formal evaluation by Dr Bonne Sibbald, now of the University of Manchester, concluded that they were effective and valuable.

In its "Academic Plan for General Practice", adopted in 1989 and published in *Occasional Paper 49* (RCGP, 1990b), the College formally adopted a national plan for research training fellowships for general practitioners:

"That at least 12 places in each Health Service region should be made available for open competition for young general practitioners to develop their [research] skills...In addition there should be some opportunities for full-time research fellowships for general practitioners."

Since 1989 the RCGP has gained more experience. It is even more convinced of the need to offer research training to young doctors completing vocational training.

However, it has also identified a group of able doctors in their thirties and early forties whose interest and commitment to general practice research is great, but who need some part-time opportunity to acquire additional skills and research qualifications.

In the area of the Exeter and North Devon Health Authority, for example, eight out of the 275 general practitioner principals (3 per cent) are undertaking formal research training likely to lead to a research degree.

Since the RCGP developed this policy the NHS regions have been involved in re-organisation. In England, the new regions are about twice the size of the old.

RECOMMENDATION: THAT THE NHS SHOULD OFFER 24 RESEARCH TRAINING FELLOWSHIPS IN EACH OF THE NEW NHS REGIONS

These fellowships should normally be linked with university departments, which will usually be of general practice. They should be mainly part time for between two and four sessions per week. In addition, a small number of full-time training fellowships leading to a PhD should be available to general practitioners.

The College currently pays a 10 per cent overhead to the host university department so that it is not out of pocket for the extra tasks of supervision and support.

Arrangements in Scotland, Wales and Northern Ireland should be pro rata for numbers so that opportunities are approximately equal throughout the UK.

*24 January 1995]**[Continued]*

The College is committed to the development of the multi-disciplinary primary health care team. It follows that arrangements need to be put in place to create research training opportunities for members of the team other than the doctors.

The College is already aware of one practice manager and two practice nurses who have acquired MSc degrees and foresees an explosion of interest in these groups in the near future. The College, however, respects the professional autonomy of nurses and other professional groups who must work out their own needs and methods for themselves.

However, it takes this opportunity, as it outlines its recommendations for general practitioners, to indicate its strong support for higher training and the gaining of research skills for all members of the primary health care team who wish to acquire them.

The RCGP is happy to advise on the establishment of these fellows as it now has several years of experience in this field.

Costs

Naturally the College has carefully considered both the costs of this proposal and the implications for the balance of medicine.

The costs are very modest in comparison with the day a week the NHS already funds for research training for nearly 4,000 senior registrars. Estimates place this RCGP programme at about half a million pounds per new NHS region per year. Meanwhile the average cost of prescriptions written by the general practitioners in a region, apart from any other costs, amount to about £400 million pa.

As for balance, the College would not wish to see any unfair discrimination in favour of general practice, but notes that the Wellcome Trust (1994) alone funds about 500 research fellows annually practically all of whom are engaged in biomedical research.

The college is confident that even after its proposed research training programme is implemented in full there will still be immense research support for biomedical science.

Encouraging small scale research in primary care

Whilst the College sees enough general practitioners already in post to take up all the research training fellowships proposed, there is a long-term need to raise the research profile in primary care and help general practitioners with interesting ideas or a general interest in research to learn more about research and to undertake small studies.

There is a need for local research skills courses to be repeated regularly. There is also a need for small scale project support. The College's Scientific Foundation Board provides small grants of about £5,000 and this needs to be replicated more widely.

RECOMMENDATION: THAT REGIONAL DIRECTORATES SHOULD FUND RESEARCH SKILLS COURSES CONCENTRATING ON RESEARCH TECHNIQUES APPROPRIATE IN PRIMARY CARE AT LEAST ANNUALLY IN EACH REGION

UNIVERSITY DEPARTMENTS OF GENERAL PRACTICE WITH RESPONSIBILITY FOR UNDERGRADUATE MEDICAL STUDENTS

The College strongly supports the establishment and maintenance of professorial departments of general practice in every medical school.

It regards it as essential that every medical school which is to have responsibility for educating medical students, the doctors of the future, should have thoroughly exposed them to the research base, the method of thinking and working of doctors in primary care. Every single student should have had first hand experience of seeing a role model of a professor of general practice actively researching his/her field.

The medical schools at the universities of Oxford and Cambridge

The RCGP deeply regrets that there is, even in 1995, no professor of general practice in the two most prestigious medical schools in the UK: Oxford and Cambridge.

24 January 1995][Continued

RECOMMENDATION: THAT THE SELECT COMMITTEE CONSIDERS WRITING TO THE UNIVERSITIES OF OXFORD AND CAMBRIDGE TO ENQUIRE HOW SOON THEY EXPECT TO BE ABLE TO ESTABLISH A CHAIR OF GENERAL PRACTICE

Funding university departments with undergraduate responsibilities

The RCGP is concerned that the funding arrangements for university departments of general practice with undergraduate teaching responsibilities are not yet satisfactory. The College has greatly appreciated the special arrangements represented by "tasked money" which has come from the NHS and has been of immense help to these university departments.

College policy is that the SIFTR funding should be decoupled so that the "R" of SIFTR (Special Increment for Teaching and Research) be separated from payments for teaching (RCGP Council Paper, 1994, unpublished). Combining payments for teaching with research made no long-term sense and the College advocated separation. It has therefore been pleased that the Culyer report (1994) also recommended this and the Secretary of State has said (December 1994) that she has accepted this.

RECOMMENDATION: THAT THE SEPARATION OF THE "R" FROM SIFTR BE IMPLEMENTED AS SOON AS POSSIBLE AND IN ANY EVENT NOT LATER THAN 1 APRIL 1997

RECOMMENDATION: THAT THE POOL OF NHS FUNDS SO ESTABLISHED BE AVAILABLE FOR APPLICATIONS FROM ALL PARTS OF GENERAL PRACTICE IN THE NHS

Obviously, the main funding for university departments of general practice/primary care which have responsibility for undergraduate teaching should come from the Department of Education via the Higher Education Funding Council for England (HEFCE) and equivalent bodies in Scotland, Wales, and Northern Ireland.

The College sees general practice now as the single most important university medical subject. It alone is now the integrating force which shows students how doctors can relate to all parts of the human body and mind simultaneously.

It can best demonstrate the special clinical skill of assessing undifferentiated medical problems of widely varying seriousness as they present. Education and training in generalist medicine, provides core clinical skills which all doctors need to learn. Only general practitioners are now true generalists seeing patients with all forms of illness in the body and mind and seeing moreover patients in the context of their family/household and working in their homes.

General practice now integrates large amounts of personal preventive care into day-to-day therapy, it has a precise knowledge of the defined population at risk and general practice best offers on a substantial scale experience for medical students of long-term doctor-patient relationships in medicine.

At a time when consumerism is of increasing importance, general practice offers medical students a work experience in which patients can easily change their doctors and in which a complaint system is conducted with a lay majority.

All these aspects of care are under-researched and all need to be studied more rigorously in the setting where most patients are seen.

The papers from the Association of University Teachers of General Practice (1984) and Fraser and Preston-Whyte (1988) show how much of the education of all medical students is logically best conducted in general practice if the recommendations of the General Medical Council are to be met. Researching optimum methods of care in general practice thus becomes an educational priority as well as an NHS one.

The College foresees the university departments of general practice/primary care becoming *Primus inter pares* among university departments. In the meanwhile, the College's policy was established as early as 1987 in the RCGP statement *The Front Line of the Health Service*, namely that university departments of general practice should be staffed and endowed to at least the same size and support as much as departments of medicine and surgery.

The College is reviewing the arrangements for the university departments of general practice and commends the same task to the Select Committee.

24 January 1995][Continued

RECOMMENDATION: THAT THE UNIVERSITY DEPARTMENTS OF GENERAL PRACTICE BE REVIEWED TO ENSURE THAT THEY ARE STAFFED AND SUPPORTED AT LEAST AS WELL AS OTHER MAJOR DEPARTMENTS IN MEDICAL SCHOOLS

National Centre for Primary Care Research

The establishment of a new National Centre of Primary Care Research at the University of Manchester has been greatly welcomed by the College.

Funding at a level of £1½ million a year for 10 years is a substantial commitment to primary care research by the NHS, which is much appreciated. It will be in a position to mount the really big and expensive studies which have only rarely been undertaken in general practice.

This centre ought to be able to achieve sustained international level contributions to research and its output is eagerly awaited.

However, what it can never do, as no single centre can ever do, is meet the needs of local research training for general practitioners settled in their practices all round the UK. Hence the RCGP calls, as its first priority, for a priority training programme through a group of research training fellowships available in every NHS region.

QUESTION 2 RESPONSE TO THE CULYER COMMITTEE (1994) REPORT

The College was invited to comment on the Culyer report.

Generally the College warmly welcomes this report and the fact that the Secretary of State has now endorsed it as policy.

From the College's point of view as the Royal College for the largest branch of the medical profession, the main principles of interest and support are as follows:

(1) SINGLE FUNDING STREAM PARAGRAPH 3.28

This is logical and strongly welcomed. The College agrees that the single stream should replace the "current diverse funding mechanisms". In particular, the College agrees that this single stream should include the research element of funding for the London postgraduate hospitals, the Non-SIFTR scheme, and other central and regional R&D and service support funds.

It is not clear about the phrase "and over time most of health care providers' own account R&D" as this may create a perverse incentive for those providers most sensitive to the importance of R&D. The College would like to discuss this latter aspect.

(2) CENTRAL LEVY PARAGRAPH 3.30

The proposal is that the funds "be conceived as a levy on all health care purchasers' allocations". In effect this is likely to amount to earmarking or top-slicing research funding which the College supports.

It also supports involvement in and participation by all purchasers, including general practitioner fundholders, but does not wish to see a big reduction in professional representation and involvement. The College considers the representation from primary care is already too small and would wish to see it increased rather than reduced in the future.

(3) BUDGETARY CONTROL PARAGRAPH 3.33

"The NHS Executive would hold the budgets created from the levy."

The College understands the need for strict accountability of public funds, especially those top-sliced or levied from funds for patient care. The College agrees that account should be taken of "assessed R&D need and capacity" and offers to advise on the national aspects of this. It services the Conference of Academic Organisations of General Practice and would expect to be consulted.

(4) PRE-PROTOCOL AND CURIOSITY DRIVEN EXPLORATION PARAGRAPH 3.36 III

This is important and the College has been invited to comment by the Select Committee which however, refers to it only in relation to "NHS hospitals". This is disappointing and the College advises that the Select Committee should be equally concerned about research in NHS general practices.

*24 January 1995]**[Continued*

RECOMMENDATION: THAT GENERAL PRACTICE BE INCLUDED IN THE THINKING ON PRE-PROTOCOL AND CURIOSITY DRIVEN RESEARCH

RECOMMENDATION: THAT ALL STATEMENTS ABOUT PRE-PROTOCOL RESEARCH AND CURIOSITY DRIVEN RESEARCH SHOULD ALWAYS REFER TO NHS GENERAL PRACTICES AS WELL AS NHS HOSPITALS

(5) PROVIDER SUPPORTED RESEARCH IN THE NHS PARAGRAPH 3.39

The Culyer Committee refers again to pre-protocol work and curiosity driven work in paragraph 3.39, where they recommend continuation of funding for NHS providers. The College agrees that this is logical, but draws the Select Committee's attention to an anomaly in that there is no analogous NHS provider organisation for general practice. Hospital consultants receive NHS support from acute NHS trusts and other consultants receive NHS support for their research from Community NHS Trusts, but the FHSAs which are the organisational NHS equivalent for general practice have never been funded to support research.

The Culyer Committee later in paragraph 3.41 again encourages providers to contribute extra to local research. The College again supports this as long as active steps are taken to ensure a level playing field for primary care research.

The College understands that several regional health authorities are funding academic posts in many specialties including in particular, public health, up to and including chairs in universities.

Now that the FHSAs in England are merging with health authorities to form NHS commissions there is a need to ensure a level playing field for primary care. The College welcomes the use of the sentence in paragraph 3.68 "It is time to place R&D in primary and community care settings on an equal footing with the acute sector". It accepts the logic of "managed competition".

RECOMMENDATION: THAT THERE SHOULD BE A LEVEL PLAYING FIELD FOR RESEARCH SUPPORT FOR PRIMARY CARE

RECOMMENDATION: THAT THE REGIONAL HEALTH AUTHORITIES AND THEN THE REGIONAL OUTPOSTS OF THE NHS EXECUTIVE SHOULD BE CHARGED WITH THE RESPONSIBILITY OF REPORTING ANNUALLY ON THE AMOUNT OF RESEARCH SUPPORT PROVIDED FOR BOTH PRIMARY AND SECONDARY CARE WITHIN THEIR GEOGRAPHICAL AREA

RECOMMENDATION: THAT THE NHS DIRECTOR SHOULD PUBLISH AN ANNUAL REPORT AS HE TAKES THE NHS RESEARCH STRATEGY FORWARD CLASSIFYING R&D EXPENDITURE INTO PRIMARY AND SECONDARY CARE

(6) THREE CATEGORIES OF FUNDING FOR NHS R&D PARAGRAPH 3.46

This radical approach cuts through much previous thinking and clarifies the issues usefully.

The College warmly supports this three point categorisation as long as there is a level playing field for both service support and the maintenance of research facilities between primary and secondary care.

(7) ACCESS TO PROFESSIONALS WORKING IN PRIMARY AND COMMUNITY HEALTH SETTINGS PARAGRAPH 3.71

The Culyer Committee proposes that "funds for service support as well as for the direct costs of R&D are made accessible to professionals working in primary and community health care settings".

Naturally, the College looked specially for this proposal and is pleased to endorse it.

The College was also pleased to note the inclusion of a specific mention of "research facilities" in relation to primary care in paragraph 3.69. It believes this needs highlighting.

RECOMMENDATION: THAT A SUBSTANTIAL PROPORTION OF THE "RESEARCH FACILITIES" FUNDED SHOULD BE IN GENERAL PRACTICE/PRIMARY CARE AND THAT THIS PROPORTION BE PUBLISHED ANNUALLY

The fact that primary care will now also be eligible for support for research facilities, where it can demonstrate appropriate research capacity, should be drawn to the attention of all health authorities/FHSAs/Commissions.

(8) NATIONAL FORUM PARAGRAPH 3.60 FOLLOWING PARAGRAPH 3.14

The College agrees that a national forum would be helpful and would be pleased to play a part in it.

24 January 1995]

[Continued

(9) FURTHER STUDY OF THE IMPACT ON INDEPENDENT CONTRACTORS PARAGRAPH 3.70

The Culyer Committee (1994) recommends further study of some of the aspects of the work of independent contractors in research. As most general practitioners are independent contractors, the College is happy to participate in this.

(10) PACKAGED PROGRAMMES PARAGRAPH 3.73

Given the limited number of units in primary care which have a significant research capacity the College agrees that: "Wherever appropriate the commissioning process should package R&D in primary care into programmes, so that a single contract can cover all the types of funding needed."

In 1989, general practice had only 157 paid research posts in British universities out of 4,006 for the specialties (Department of Health, 1989) which meant one post per 161 general practitioner principals, whereas for specialist medicine the ratio was 0.43 academic posts per consultant.

QUESTION 3 ADDITIONAL CHALLENGES OR OPPORTUNITIES FOR UK MEDICAL RESEARCH WHICH HAVE NOT BEEN ADDRESSED BY THE NHS STRATEGY OR BY THE CULYER REPORT

The College recognises five issues which apply:

- (1) The discipline of the clinical generalist
- (2) The postgraduate university departments/institutes of general practice
- (3) The merit award scheme
- (4) Overhead arrangements
- (5) Use of fundholding savings for research.

(1) THE DISCIPLINE OF THE CLINICAL GENERALIST

The success of general practice in managing 87 per cent of all clinical problems in the NHS without referral to the hospital service (Office of Population Censuses and Surveys, 1991), at a far lower cost per patient and per consultation to the NHS than any other medical service has attracted much attention.

Now that it has also been found that in consumer satisfaction surveys such as *British Social Attitudes* (Jowell, Witherspoon and Brook, 1990), dissatisfaction with the NHS is less in general practice than in either hospital outpatients or hospital inpatients; the attraction of passing more and more responsibility to general practice is extremely attractive to Government and NHS managers.

Paradoxically, this very success contains dangers. The first is simple overload. Just as the NHS reforms emphasised the importance and the logic of money following the patient, so when increased responsibilities are taken on in primary care whether by day care surgery or earlier discharge home, so funding should follow.

The second danger is greater, although less obvious, and is more insidious. General practice is at risk of being seen only in relation to the secondary care services, eg the "gatekeeper" role as or as an early discharge agency.

The core values of general practice as a medical discipline in its own right are in danger of being devalued and even lost. Yet it is these very core values which make general practice in the British NHS possible.

The College therefore wishes to underline the role of the general practitioner as a clinical generalist. It has established a Working Party, chaired by Professor Nigel Stott, which is expected to report within the next few months. In the meanwhile, it encloses an editorial published in the *British Medical Journal* (Pereira Gray et al., 1994) entitled "Generalists in Medicine" (see Appendix 3), which summarises some of the main issues.

The conclusion is that general practice needs research in its own right and that the elucidation through research of the nature and best means of developing these core aspects of general practice, for example primary assessment, early diagnosis, domiciliary care, family care, and continuity of care, is of increasing importance.

RECOMMENDATION: THAT THE CORE ASPECTS OF GENERAL PRACTICE AS A DISCIPLINE ARE IN DANGER OF BEING OVERLOOKED AND NEED TO BE RESEARCHED MORE

The Conference of Academic Organisations in General Practice (1994) in its booklet (see Appendix 4), draws a distinction which the College, as a member of that Conference, endorses between research "in" and research "on" general practice.

Whilst valuable research can be done and has been done by colleagues in other fields examining data and research on general practice, there can be no doubt that the best understanding and the deepest value can only be extracted when the research is conducted by primary care research workers in whose discipline it is.

24 January 1995][Continued

There are many nuances in patterns of behaviour, the interpretation of general practitioner records, and the significance of what was not done which can only be fully appreciated by those clinically proficient in the field.

The College supports multidisciplinary research, but is concerned that research, especially on the primary/secondary care interface should always have substantial primary care involvement at the design, supervision and reporting stages.

RECOMMENDATION: THAT MORE RESEARCH NEEDS TO BE DONE “IN” AS WELL AS “ON” GENERAL PRACTICE

(2) POSTGRADUATE UNIVERSITY DEPARTMENTS/INSTITUTES OF GENERAL PRACTICE

In 1987 there were over 100 professors in the postgraduate institutes of the British Postgraduate Medical Federation, but there was only one professor of general practice in Britain in a postgraduate department (RCGP, 1987). There are, in 1995, now three such general practice professors, but the disparity remains substantial.

General practice has developed a number of postgraduate university departments/institutes of general practice, in universities which do not have responsibility for teaching undergraduate medical students.

The College has welcomed these and has called in 1987 and 1994 for them to be supported.

They face a number of special problems, especially in funding, and for example, they receive no funding from SIFTR, since they do not have prime responsibility for undergraduate medical students.

Simultaneously, their staff may not be eligible for funding through the Higher Education Funding Councils' research assessment exercise, as their posts are usually not paid through the core funding of their university, but by various outside sources. They may therefore be doubly disadvantaged.

RECOMMENDATION: THAT THE POSTGRADUATE UNIVERSITY DEPARTMENTS OF GENERAL PRACTICE BE REVIEWED

(3) MERIT AWARDS FOR GENERAL PRACTITIONERS HOLDING FULL- OR PART-TIME SALARIED APPOINTMENTS IN UNIVERSITIES/MEDICAL SCHOOLS

The College's policy on merit awards was first set out in 1987, namely that there should be no discrimination against those general practitioners who take up part-time or full-time appointments in medical schools or universities.

Once they accept salaried employment in these organisations the College believes that general practitioner academics should be treated exactly the same as all other academic doctors with clinical responsibilities.

The College was pleased that this policy was endorsed by the Conference of Medical Royal Colleges and Faculties in the UK and a letter from the then Chairman, Professor Sir Dilwyn Williams (1990, see Appendix 5) was sent to the then Secretary of State for Health, Mr Kenneth Clarke.

Unfortunately, this coincided with all the changes in the NHS reforms and was not implemented. The next step was that the Department of Health set up the Kendell Committee which reported on distinction awards in 1994. The College was pleased that its case was acknowledged and no flaw was found (paragraph 8.6) in that case. However, in the next paragraph (paragraph 8.7) for no clear reason, the Committee declined to implement the policy.

The exclusion of academic salaried general practitioners on the staff of universities and medical schools is odd when academic public health doctors, postgraduate medical deans, and community dentists are all included as is the contribution from medical managers. The current policy represents a serious form of discrimination against academic general practice, just when it needs incentives and rewards for good performance.

Given the Culyer Committee's adoption of 11 “values” two of which are that “Research and development are the key stones of a knowledge based evaluative culture in the NHS” and that “Research should follow explicit priorities”, reform is indicated.

Given also the new policy of a “primary care led NHS”, the RCGP invites the Select Committee to advise the Department of Health to remove this discrimination against university general practice/primary care.

*24 January 1995]**[Continued]*

RECOMMENDATION: THAT THE EXCLUSION OF PART-TIME AND FULL-TIME SALARIED ACADEMIC DOCTORS IN GENERAL PRACTICE IN THE MERIT AWARD SCHEME BE REMOVED.

(4) INCONSISTENT PUBLIC POLICY ON RESEARCH OVERHEADS

In the universities the Committee of Vice Chancellors and Principals now demands that overhead charges on grants be levied at rates which reflect the full university costs, which are not less than 40 per cent.

This is the rate that the MRC, with Government funding, pays on staff employed on its funded research.

Yet within another part of the public sector, the NHS R & D insists on paying overheads of only 15 per cent in some NHS regions, and one up to 1994, paid no overheads at all.

These inconsistencies in public policy lead to local difficulties and affect general practice particularly. Inadequate overheads may force general practice academics into non NHS research. They seem unnecessary as one Government department is funding work in another.

RECOMMENDATION: THAT OVERHEAD PAYMENTS FOR PUBLICLY FUNDED RESEARCH BE RATIONALISED AND MADE MORE CONSISTENT

(5) FUNDING RESEARCH FROM FUNDHOLDING SAVINGS

The NHS Executive letter (EL(94)79) entitled "Developing NHS purchasing and GP fundholding" was dated 20 October 1994. It includes in paragraph 6 a new authority for the use of GP fundholders' savings to be extended to include research and development with effect from April 1995.

The College welcomes this provision since purchasing authorities have frequently funded research posts in secondary care in the past.

RECOMMENDATION: THAT THE USE OF FUNDHOLDERS' SAVINGS FOR RESEARCH BE MONITORED

CONCLUSION

General practice research is a concept whose time has now come.

For many years general practice research has been developing steadily and it is now stronger than ever before. However, despite the fact that general practice is the largest branch of medicine and despite its special integrating potential as the discipline of clinical generalists, there are severe shortages of training opportunities.

The recent decision of the NHS (NHS Executive, 1994) to plan for a "Primary care led NHS" marks a natural time to implement a priority programme of training in research skills. This will start to remedy longstanding deficiencies in training provision.

If the wishes of the Government and the current policies of the Department of Health are to be properly implemented there will need to be a major shift of emphasis towards research in primary care.

This paper makes recommendations for consideration by the Select Committee as to how this can be achieved. However, two stand out: a priority programme of research training fellowships and establishing NHS funded research general practices.

(1) RESEARCH TRAINING FELLOWSHIPS

The College recommends the immediate establishment by R&D Directors of 12 research training posts in each new NHS region, funded to allow a significant group of trainees to acquire research degrees.

Secondly, and in addition, the College recommends the immediate establishment of 24 part-time research training posts in each new NHS region to be made available by competition among NHS general practitioners.

The historic deprivation of research training in general practice can only be tackled by a priority training programme and the RCGP is confident that such a programme would not only be well taken up, but would put the discipline on a stronger footing for the future.

(2) RESEARCH GENERAL PRACTICES

Much of the success of research in secondary care has been because systems have been developed to provide organisational settings for specialist research, mainly in the hospital service. There has been no organisational equivalent in general practice research of the teaching hospital.

24 January 1995]

[Continued

The College pioneered the teaching (training) practice (Irvine, 1972) and they have worked exceptionally well. The College now believes that the time is right to build on that experience and to develop NHS funded research general practices as well.

SUPPLEMENTARY EVIDENCE

The College would be pleased to amplify any part of this evidence or produce supplementary evidence on any point the Select Committee requires.

APPENDICES—(not printed)

1. Cover of *Developing NHS purchasing and GP Fundholding*.
2. Gray DP (1991) Research in general practice: law of inverse opportunity. *British Medical Journal* 302, 1380-2.
3. Gray DP, Steele R, Sweeney K and Evans P (1994) Generalists in medicine. *British Medical Journal* 308, 486-7.
4. Conference of Academic Organisations in General Practice (1994) *Research and General Practice*. Exeter, RCGP.
5. Letter from Professor Sir Dillwyn Williams to Secretary of State for Health on merit awards.

References

Department of Health, Medical Manpower and Education Division (1994) Medical and dental staffing prospects in the NHS in England Wales 1990. *Health Trends*, 23, 132-5.

Association of University Teachers in General Practice (1984) *Undergraduate Medical Education in General Practice*. Occasional Paper 28. Exeter, RCGP.

Budd W (1873) *Typhoid Fever*. London, Longman Green.

Conference of Academic Organisations in General Practice (1994) *Research and General Practice*. Exeter, RCGP.

Culyer Committee (1994) *Supporting Research and Development in the NHS*. London, HMSO.

Department of Health (1989) Medically qualified staff of universities, medical schools and institutes—England and Wales 1988. London, Department of Health.

Department of Health, Medical Manpower and Education Division (1991) Medical and dental staffing prospects in the NHS in England and Wales 1990. *Health Trends* 23, Table 2 132-141.

Department of Health (1993a) *Health and Personal Social Services Statistics for England*. 1993 edition. Table 5.31. London, HMSO.

Department of Health (1993b) *Research for Health*. London, Department of Health.

Fraser R and Preston-Whyte E (1988) *The Contribution of Academic General Practice to the Undergraduate Medical Curriculum*. Occasional Paper 42. Exeter, RCGP.

House of Lords, Select Committee on Science and Technology (1988) *Priorities in Medical Research*. London, HMSO.

Irvine DH (1972) *Teaching Practices*. Report from General Practice 15. Exeter, RCGP.

Jowell R, Witherspoon S and Brook L (1990) *British Social Attitudes*. 7th Report. Chapter 1, p 17. Aldershot, Gower Publishing.

Kendell Committee (1994) *Report of the Working Party on the Review of the Consultants' Distinction Awards Scheme*. Paragraphs 8.6 and 8.7. London, Department of Health.

Mackenzie J (1916) *The Principles of Diagnosis and Treatment in Heart Affections*. London, Henry Frowde, Hodder and Stoughton.

NHS Executive (1994) *Developing NHS Purchasing: Towards a Primary Care led NHS*. Leeds, NHSE.

Office of Population Censuses and Surveys (1991) *General Household Survey 1989*. Table 4.30 and Table 4.33. London, HMSO.

Pereira Gray D (1991) Research in general practice: law of inverse opportunity. *British Medical Journal* 302, 1380-82.

Pereira Gray D (1992) The university story. In *Forty Years On. The Story of the First Forty Years of the Royal College of General Practitioners*. pp 89-107. London, Atalink for RCGP.

Pereira Gray D Steele R Sweeney K Evans P (1994) Generalists in medicine. *British Medical Journal* 308, 486-87.

Pickles W (1939) *Epidemiology in Country Practice*. London, RCGP.

24 January 1995]

[Continued

Resource Allocation Working Party (1976) Report. London, Department of Health.

Royal College of General Practitioners, Office of Population Censuses and Surveys and Department of Health and Social Security (1982) *Morbidity Statistics from General Practice 1970-71*. London, HMSO.

Royal College of General Practitioners (1987) *The Front Line of the Health Service. Report from General Practice 25*. London, RCGP.

Royal College of General Practitioners (1990a) *Fellowship by Assessment. Occasional Paper 50*. London, RCGP.

Royal College of General Practitioners (1990b) An academic plan for general practice. In *A College Plan—Priorities for the Future. Occasional Paper 49*. London, RCGP.

Royal College of General Practitioners (1984) SIFTR. Council paper. Unpublished. London, RCGP.

Salisbury C (1983) Visiting through the night. *British Medical Journal* 306, 762-4.

Secretaries of State for Social Services, Wales, Northern Ireland and Scotland (1986) *Primary Health Care. An Agenda for Discussion*. Cmnd 9771. London, HMSO.

Secretary of State for Health (1994) Statement at R & D reception. 15 December.

The Times (1994) Obituary for Dr John Fry.

Wellcome Trust (1994) *Annual Report*. London, Wellcome Trust.

Examination of witnesses

PROFESSOR DENIS PEREIRA GRAY OBE MA FRCGP, General Practitioner, Exeter; Professor of General Practice and Director of the Postgraduate Medical School, University of Exeter; Chairman of Research, RCGP; DR WILLIAM MCN STYLES OBE MA FRCGP, General Practitioner, London; Chairman of Council of the RCGP; Regional Adviser in General Practice, North West Thames; PROFESSOR ROGER JONES MA DM FRCP FRCGP, United Medical & Dental Schools; Chairman, Heads of Departments Group, Association of University Departments of General Practice; DR ANDREW FARMER MA MRCGP, General Practitioner, Thame, Oxfordshire; joint first General Practitioner to be awarded a Harkness Fellowship; appointed to an RCGP research general practice in 1994; AND DR KIERAN SWEENEY MA MRCGP, General Practitioner, Exeter; joint first General Practitioner to be awarded a Harkness Fellowship; RCGP Research Training Fellow; the Royal College of General Practitioners, were called in and examined.

Chairman

340. Thank you very much for coming. May I invite you, if you so wish, to make any opening statement that you feel would be appropriate.

(Professor Gray) Thank you very much, my Lord Chairman. We would like to begin by saying how much we appreciate the chance to come and to give evidence and to give it verbally in this way.

341. One little point of clarification that I should perhaps ask at the outset is that the Medical Research Council does of course fund 60 training fellowships for research in medicine every year open to all branches of medicine, and that is a point which I think we would like to have on the record. Now, do you wish to make an opening statement or shall we go straight on into the questions?

(Professor Gray) I would be very happy, my Lord Chairman, to make a short opening statement. The College believes that this is a very important time for a review of medical research with particular reference to the NHS reforms and the NHS policy for research. Essentially, as we have said in our evidence, we wish to put forward the point that general practice is by far and away the largest branch of medicine, twice as large in its highest grade as all other consultants in practice put together, that, as the Secretaries of State have said, 90 per cent of the contacts between the population and the Health Service take place in general practice and that the whole thrust of policy internationally and nationally is to place greater responsibility on general practice both clinically and

managerially. The College suggests, and the central thrust of our evidence is, that given that background and given the long-standing relative deprivation of research training opportunities in general practice, this is the time for a major statement of policy by the Government and the Department of Health, we hope on the recommendation of your Select Committee, my Lord Chairman, to put in place a series of recommendations which we have put before you which we think could make a huge difference to the development of research training in general practice and in the quality of care for patients in the National Health Service. We have listed all those recommendations in our paper and we would be very happy to speak to any part of them which your Committee wishes to explore. We would single out for particular consideration our view that there is an urgent need for research training fellowships both at the stage immediately after vocational training and for established principals. We believe that there is an urgent need, particularly for research practices, funded by the National Health Service, and for a number of administrative reforms which we have listed in our paper. We will be very happy, my Lord Chairman, to try to help your Committee in any way that we can.

342. To take up the point you raised about research fellowships, are you aware as to whether any of the MRC research training fellowships have been held by general practitioners and would you care to comment on the MRC Research Framework?

24 January 1995]

PROFESSOR DENIS PEREIRA GRAY, DR WILLIAM MCN STYLES,
 PROFESSOR ROGER JONES,
 DR ANDREW FARMER AND DR KIERAN SWEENEY

[Continued]

[Chairman contd.]

(*Professor Jones*) I think only a very small number of MRC training fellowships have been taken up in general practice. I cannot give you an exact number today. The MRC Research Framework is a large organisation of practices in the United Kingdom who are principally involved in collecting data for large-scale trials of therapy or medical interventions. Although it clearly is an important Research Framework, it is not the only one and it may not be the best one for promoting research in and into general practice. I think that is how one would summarise it. The general practitioners involved in the framework tend to be, with their practice nurses also who are involved in that framework, data-collectors rather than initiators of research. Although it is a well-administered framework, it is not administered or led by primary care, although, having said that, the new chairman of the steering committee is Professor Stott whom I am replacing on this group, so it is a framework for collecting information and it is not a framework with a track record of developing research ideas from general practice or indeed acting as a career or training pathway into academic general practice.

343. Would it be fair to say that the great strengths of research in general practice are, first, in epidemiology, in so-called health services research, looking, for instance, at outcomes, and perhaps at the performance of clinical trials? It would be much more difficult, would it not, for general practitioners to be involved in what one would call basic biomedical research, using laboratory-based techniques, for example, which are more readily conducted in hospital?

(*Professor Jones*) Certainly I would not dissent from that, and I would simply add to that that general practice research as well as dealing with epidemiological and clinical therapeutic issues is involved in research into doctor/patient relationships, the use of resources, which often depend on the analysis of things like medical decision-making which involves the skills of many others other than clinicians, like behavioral and social scientists.

Lord Perry of Walton

344. Could I ask where you envisage the training fellowships would actually be held and who would do the training?

(*Professor Gray*) The position is that these would be open for competitive advertisement. They would be in two groups. The first group we are recommending is for those doctors immediately completing vocational training for whom there is no provision nationally at present, apart from one or two experimental projects. We would expect that those relatively young doctors would be placed in association with the university departments of general practice and we have some pilot models at present. The second group would be competitively advertised for established general practitioners and here we would offer two members of our team, Dr Farmer and Dr Sweeney, who have in fact been appointed to Harkness training fellowships on competitive advertisement and who would be pleased to speak about what the experience did for them. We

would expect them to remain in their practices, but we would expect that the great majority would choose to work in relationship with university departments of general practice.

345. You would not regard the training in such methods as epidemiology and such methods as statistics and this kind of thing in the appropriate specialised departments as falling within that sort of ambit?

(*Professor Gray*) We would agree that statistics and research methodology and epidemiology are core skills of great importance to all doctors researching into medicine, but the university departments already either have members of staff who are non-medical scientists or, in other cases, work very closely with the university departments of statistics or mathematics and statistics and have good working relationships within the universities with these core skills. We certainly believe that it is essential that these young doctors should learn those skills, but we do not think it is necessary for them to leave the clinical discipline to do so. There are examples. For example, there is the recent MD degree of a general practitioner in Northern Ireland, Dr MacAuley, who has just been seconded to a department of epidemiology and preventative medicine, but we would not exclude that of course, and it must help to persuade them towards making the most appropriate arrangement, but we would envisage that the great bulk of them would be in relation to their discipline, their own university discipline of general practice. I think both Dr Farmer and Dr Sweeney would be happy to answer any questions about the kind of doctor and the kind of experience and benefits that they might gain from such fellowships.

Chairman

346. What is the incentive that would make such a research training fellowship attractive to a young doctor who, say, had just completed a three-year vocational training programme? What incentive would make that attractive other than going straight into a principal's post in practice?

(*Dr Sweeney*) The incentive is the increasing awareness that the young principal in general practice develops that his undergraduate training has not been entirely appropriate for the job that he sets out to do and a sense of dissatisfaction at the absence of role models or a career structure which is available to his colleagues and peers in hospital medicine who can progress with a rich background and experience of the different departments in hospital medicine. So the incentive is dissatisfaction and the pressure is, I think, to look for avenues for developing a career independently. There are also models of financial disincentives at the outset where courses and other opportunities may incur personal expense, but I think that the initial impetus is to gain expertise in the primary disciplines and then attempt to develop expertise in the particular discipline of researching problems in general practice.

347. Is there not just a potential conflict here, in that a training fellowship, for instance, in other branches of medicine is often held by a doctor who

24 January 1995]

PROFESSOR DENIS PEREIRA GRAY, DR WILLIAM MCN STYLES,
 PROFESSOR ROGER JONES,
 DR ANDREW FARMER AND DR KIERAN SWEENEY

[Continued]

[Chairman *contd.*]

moves out of his or her parent discipline, such as medicine, into a department, say, of molecular biology, and then comes back to carry out research using that expertise? What is different about general practice, because surely the doctor doing the research in general practice is conducting research rather than necessarily being trained? Is it not appropriate, as Professor Gray said, that some such doctors holding training fellowships might go out into a specialised department to acquire specialised expertise before coming back to conduct the research?

(*Dr Farmer*) For example, the opportunity I had to go to the United States for six months, I actually spent that time in health research a policy at Duke University, Durham, N Carolina, and there I had the opportunity to spend time taking some courses looking at how health policy decisions are reached there, looking at modelling techniques for controlling HIV infection, looking at ways of developing that and also in stroke prevention and being involved in some research studies to see how doctors dealt with these issues and how investigations were carried out and ways of trying to make those more efficient, so that was totally out of my experience of general practice and was very rewarding.

Lord Butterfield

348. Let me just say that I have always thought that people who had got interested in research in general practice might be regarded as perhaps late developers. I wondered two things. What kind of qualities do you think that young men and women who are applying for these research fellowships ought to have and have you got very many of them in general practice these days?

(*Professor Gray*) I think the College view is that the qualities would be essentially the same as people being offered training fellowships in any other branch of medicine. We would be looking for considerable energy and ability. They must be people who have a real ability to deliver. We would want enthusiasm for their branch of medicine and a real commitment to raising its standards and to finding new knowledge and improving its way of practice, and we would want somebody who was open-minded and ready to accept a substantial amount of training which in our field is likely to lead not only to the kind of statistical and research skills which have already been mentioned, but increasing skills in health economics and in other techniques, so it will be very competitive and it will be very demanding. As far as Lord Butterfield's second question is concerned, we are quite confident in terms of the numbers in our paper that we will be able to find doctors of the necessary calibre and we believe that a large number of very able doctors are without research training opportunities at the moment. Perhaps I would like to ask Dr Farmer just to fill in the fact that in fact people like him and his ilk are available to take these fellowships if they are available.

(*Dr Farmer*) Yes, certainly. Looking at my colleagues around Oxford, for example, at the moment the task I have is being responsible for a network of 16 general practitioners who are involved in fairly small-scale audit work and who have been

involved in this and they are all very enthusiastic actually to take it further, but what they lack is the level of resources and facilities to develop that and the training, but they all have a great enthusiasm for it and it is very stimulating meeting with them, but there is not the framework at the moment for them actually to be involved, although there is a culture starting.

Chairman

349. What you have said implies that you are looking at a kind of double mechanism. On the one hand, you are looking at a greatly increased number of training fellowships for general practitioners to be trained in research methods and, secondly, you are looking for greater opportunities for general practitioners once trained to use those skills in conducting research. By this you imply either that there should be research general practices or that there should be funded research sessions available for GPs in practice to embark upon research projects. Are those two mutually exclusive or do you favour both mechanisms?

(*Professor Gray*) We favour both mechanisms and we would see the research basis of general practice as being in three parts. It would be principally the university departments, secondly, the College's own research units and, thirdly, a number of practices which would be major researchers in their own right and so we would certainly, as far as your last point is concerned, envisage both individual general practitioners having research contracts and doing research and research practices, and Dr Farmer has just been appointed to the first of the College's own research practices which we initiated recently.

Lord Perry of Walton

350. There are quite large numbers, and I speak as one who was involved in the training of medical students, who would do a year doing an intercalated BSc. Do you get many of them in general practice who have got a research training in laboratory methods and at least, therefore, understand the nature of that kind of research?

(*Professor Jones*) Interestingly, we surveyed about 400 GPs in the north of England last year, or the year before last, and there did seem to be a link between doing an intercalated BSc and an interest or indeed participation in research once in general practice.

351. There is a link?

(*Professor Jones*) Yes, a positive link.

352. How about the numbers? Are there many of them?

(*Professor Jones*) That is difficult. I think in this particular survey it was a tiny percentage of the total number of general practitioners, but that is looking at a particular slice and one would have to look at the particular cohort and 40 per cent of the students do one now, so in a few years' time the numbers are likely to rise.

24 January 1995]

PROFESSOR DENIS PEREIRA GRAY, DR WILLIAM MCN STYLES,
 PROFESSOR ROGER JONES,
 DR ANDREW FARMER AND DR KIERAN SWEENEY

[Continued]

Chairman

353. How is undergraduate teaching in general practice funded and how are vocational, postgraduate and continuing education of GPs funded?

(*Professor Jones*) The funding for undergraduate teaching in general practice, which is the responsibility of the university departments whose principal responsibility to undergraduates rather than postgraduates, is in two parts really. The first is the HEFC core funding for departments which provides support for some, rarely all, of the academic staff working in the department. Added to that in the last two years has been the tasked money from the Department of Health through regions which has been a payment based on student numbers made in anticipation of a resolution of the SIFTR negotiations.

354. That money then presumably comes out of SIFTR, or does it not?

(*Professor Jones*) No, it does not.

355. Hence there is a separate source of funding from central government to support teachers in general practice?

(*Professor Jones*) Yes, it is to support the service costs of teaching. In other words, it pays for extra posts so that others can be freed up to teach and, as I say, this has been paid for three years and a fourth year has been advocated, but it is not promised, and it is paid in anticipation of a resolution of the SIFTR agreement. General practice gets nothing at all at present from SIFTR.

356. So this would be comparable to the SIFTR component for teaching undergraduates in hospitals, except that it comes direct. Does it go direct to the family health service authorities?

(*Professor Jones*) It is analogous, but not comparable.

357. It is analogous.

(*Professor Jones*) It is tiny.

358. Understood.

(*Professor Jones*) It has been distributed in various ways and it has not always been distributed satisfactorily. I do not know whether it is appropriate to say this to this Committee, but some departments have had great difficulty in prising the money out of their regions and others have had less difficulty. It has not been a straightforward administrative issue. That is the first part.

359. In hospital-based specialties, there has been an increasing trend for regional health authorities to fund university chairs. The chairs of general practice in the United Kingdom, are they all funded by the Higher Education Funding Council, or are any of them, to your knowledge, funded with money which comes from the NHS through the regions?

(*Professor Gray*) I think the majority are HEFC.

(*Professor Jones*) Not all.

(*Professor Gray*) There is at least one which is funded by an RHA and there is at least one which has been required to fund itself.

360. Through the actual income of its practice?

(*Professor Gray*) From its department, its university chair, so the university department is being

required to seek funds to maintain its own chair in one case.

Lord Butterfield

361. There have been some charitable monies?

(*Professor Jones*) Yes. My own chair in Newcastle, was funded on a charitable basis, and there are one or two other examples.

(*Professor Gray*) The early ones particularly, such as Dorothy McKenzie of Scotland, and indeed General Accident, a private firm, funded the Glasgow chair a few years ago.

Chairman

362. Are those chairs then funded on an endowment basis or on a continuing recurrent basis by charities?

(*Professor Jones*) On an endowment basis.

Lord Butterfield

363. That was true for the one at Guy's.

(*Professor Gray*) I think, my Lord Chairman, we would be happy to give you supplementary evidence of the facts. We are speaking off the cuff on this point.

Chairman

364. Yes, we would like to have the details.

(*Professor Jones*) That was the first part, the funding for undergraduate teaching. The second part is the payments currently made to GP teachers who are not academic appointees, but GPs working in NHS practice; the payments are made to them by the family health service authorities. The GP teachers are currently paid £12 for a session in which one or two students are taught during, say, the morning surgery, on house calls and whatever else takes place that morning. At the moment GPs are teaching for love and not for money in those circumstances.

365. And vocational, postgraduate and continuing education?

(*Dr Styles*) The funding for this comes from the NHS and is channelled in different ways. The infrastructure funding both for vocational training and for continuing education comes through the postgraduate dean network and the regional adviser in general practice is the budget manager of the resources for the infrastructure of continuing education and vocational training, the GP tutors and the vocational training course organisers. The trainees, the vocational trainees themselves and the general practitioners who are selected to train them, they are actually funded through the General Medical Services budget and it is in fact a policy of the College which we reviewed last year and we would wish to see a change to that, so that in future all the resources both for vocational training and for continuing education were channelled through the postgraduate dean and the regional adviser in the future.

366. Then to clarify that once more, that money goes nowhere near the individual NHS trusts, for example, but it is money that comes through the budget of the postgraduate dean and the regional adviser in general practice at the regional level?

(*Dr Styles*) That is correct.

24 January 1995]

PROFESSOR DENIS PEREIRA GRAY, DR WILLIAM MCN STYLES,
 PROFESSOR ROGER JONES,
 DR ANDREW FARMER AND DR KIERAN SWEENEY

[Continued]

Lord Gregson

367. What happens when the regions disappear? Are they protected posts?

(*Dr Styles*) That is a big debate at the present time and there is considerable confusion about what the future arrangements are going to be and the way is not clear, but I think that the money will be channelled through some mechanism to the regional outpost level.

Chairman

368. And we understand that the regional postgraduate deans will continue to be appointed. They are appointed by the universities, but paid from NHS money.

(*Dr Styles*) That is right, and so are regional advisers.

369. And so are regional advisers in general practice, yes. So to make it quite clear from the standpoint of our enquiry, this money is not a charge against SIFTR at all?

(*Dr Styles*) No.

370. It is separately provided from central government to regions and regions ring-fence that money for postgraduate and vocational education?

(*Dr Styles*) So far they do, yes.

Lord Butterfield

371. But it is not very much money.

(*Dr Styles*) No, indeed.

Chairman

372. The College has begun to appoint "academic general practices", and you recommend that the NHS should do the same. What do you see as the characteristics of an academic general practice and its role, its costs, and how many such practices do you envisage?

(*Dr Farmer*) The College appointed our practice and we were very grateful to the College for giving us that money. That money, I think, or at least I hope, has three characteristics. I think we try to maintain a culture of research and teaching; we try to be well organised; and I think we have in the past actually done some useful research projects. I think in those three areas there are things which are important. The sort of culture which we try to keep there is one of enquiry and I think from the level of the receptionists to the nurses through to ourselves as doctors, we try and ensure that everyone asks questions so that we can try and see if there are ways we can improve what we are doing, so that is a cultural thing there. Also in terms of the teaching of undergraduates and vocational trainees, I think all the staff are involved in that and it allows us to have a culture in which we can talk about developments, try and pose research questions and to try to start to answer them. In terms of organisation, I think we are reasonably well organised. We have neat medical records and we have well-organised computer systems. We have had a computer in the practice for over ten years and for the last five years we have used that extensively to record information about diagnoses, about prescribing, about preventative activities, so we have a database which we can use to answer these

questions. For example, we have been able to pose questions about the management of patients with particular diseases recently which have been prominent and we have actually been trying to look at our management of them. In terms of the track record of research, I think we have been involved in projects on and off over at least the last ten years that I have been in the practice and well before that. The sort of thing we have been involved in, for example, was a project to look at screening for colorectal cancer and that was done in collaboration with the university department and the hospital. We provided a setting in which they could do a randomised trial of particular methods of screening to answer some questions which I think are going to be very important in the future and on the back of that we were able to pose our own research questions about which patients responded particularly well and as to what were the best methods of screening. That was something which we as GPs in practice were able to formulate as a research question and to work with the university department to firm that up and to be able to carry it on. Now, we enjoy doing that very much and it is very stimulating to be involved in that, but what we have found is that because of the sheer logistics and the time that takes up in writing it up and so on, at the end of the time it fizzles out because we do not have the sort of slack in the system to be able to start posing other questions and start taking on other projects so that the two run continuously, and I hope that the sort of funding the Royal College has been able to give us will actually help us move on in that way, so that rather than just stop-start, we can actually have a continuous programme of research.

373. How does the College fund them and how many are there? What would you say are the excess costs of a research practice over and above a straightforward general practice? How is that done? After all, the funding of general practice now is something like 50 per cent fee and 50 per cent capitation, is it not, in the NHS; so is this done by adding a surcharge to the capitation fee or how are the excess costs of a research practice handled?

(*Professor Gray*) If I may take that, the problem has been that the excess costs of the research practices have never been funded and are not funded through the NHS at the moment, and this is the College's attempt through the research practices to begin to compensate for the infrastructure costs that we are talking about and which are in effect extra work, extra researches, more detailed record-keeping, more detailed computer use, extra staff, longer consultations, more follow-up and all the rest of it. So the answer is they have never been covered before and this is the first attempt to find an organisational answer to that problem. As far as the numbers are concerned, the College has initiated this idea, but we are delighted that the South & West Regional Directorate is currently advertising ten such practices at an annual rate of £12,500 a year. We broadly welcome that. We do not yet know whether that is actually the right figure, but it is a very good guesstimate and we are supporting them strongly, but we do not yet have the evidence of exactly what is the optimum. However, for the moment £12,500 we think is an excellent start, annually for a three-year contract.

24 January 1995]

PROFESSOR DENIS PEREIRA GRAY, DR WILLIAM MCN STYLES,
 PROFESSOR ROGER JONES,
 DR ANDREW FARMER AND DR KIERAN SWEENEY

[Continued]

[Chairman contd.]

374. But the College has presumably funded research practices by giving a supplementary sum to those practices in order to cover those excess costs. Where has the College got the money from and, secondly, how much have you been giving to those practices?

(Professor Gray) The College has had to fund this entirely out of the subscription income of its members. It has no other source and it is nothing to do with the National Health Service, in the sense that it is not a capitation or anything, but it is College money, College subscriptions. This was a pilot study which it started at £5,000 a year which we believe is much too low, but it was a way of just getting the thing off the ground very quickly and the present College position is likely to be, and my Council have not yet met to endorse this, but it is likely to be close to the South & West Regional Health Authority position of £12,500 on a three-year run.

375. Depending of course on the size of the practice and the number of partners, I presume?

(Professor Gray) Well, yes and no, my Lord Chairman. Some of the infrastructure costs are better and more expensive computer equipment and having a computer operator and then having a doctor giving a commitment to research. It is not entirely dependent on the size of the practice unit, but, broadly speaking, there will be a relationship and it is about having a real research presence in general practice and it is not so important that one's practice has four partners or six.

376. Can you give us a rough percentage figure to indicate what percentage of the total practice budget, £12,500 per annum amounts to?

(Professor Gray) The average general practitioner has an income from the National Health Service of about £42,000 a year.

377. Per practitioner?

(Professor Gray) Per practitioner, that is the income, and then there is a figure for expenses which, and I do not know if the Chairman of the Council has it, but roughly it will more than double that and it will go on premises and staff and the workings.

378. So that if you get a three-man practice, for example, or a three-woman practice, £12,500 would be really quite a small percentage of the total?

(Professor Gray) Very small, but I think we would suggest, looking at it the other way round, that this is about making a unit of time available for one partner at present, whether one of six or one of three, to find, say, a day a week clear actually to concentrate on research and have some staff support in the practice to develop research ideas. As far as numbers are concerned, we do not have a final position, but we are seeking initially to create, if possible, about 100 of these and then we believe they should be rigorously evaluated.

379. What is the reaction of the patients to being the patients of a research general practice?

(Dr Farmer) Well, I think on the whole they are delighted to be involved in research. To take an example of the large research project we are involved in, people actually felt that it was a sign of a very caring and forward-thinking practice. I do not think we have had any adverse reactions about that at all.

It has a lot of spin-offs for them. They can see their doctors and, for that matter, nurses and the receptionists as being involved in something they are very enthusiastic about, and they are thorough because that is one of the spin-offs of adopting a more rigorous research bent towards the practice and one actually looks more widely and thinks more widely.

380. So you are not aware of any comments about human guinea pigs?

(Dr Farmer) One of the things that we have done over the years is we have linked up with university departments of the specialties and they have come to us and said, "Could we use your patients for our research projects?" and I think it has been a real privilege for us to be able to say to them, "Well, you can, but you are going to have to sit down with us and discuss what you are doing in terms of research". We think one of the aspects that we bring to that which is sometimes missing is actually to say, "We think that the way you are going about doing that would perhaps upset someone and could we suggest modifying it in this way?" or perhaps undertaking a small pilot of 20 different patients in our practice and then just seeing what the problems are and ironing those out before going to another wider spread of GPs. That is one of the things we have been able to offer as a practice.

(Professor Gray) I think Dr Sweeney has the highest profile of our team because he is the assistant correspondent on *The Times* who has featured most prominently and he will probably be best placed to answer whether any of the patients in his practice had any problems with his fairly high-profile activities.

(Dr Sweeney) I would only underline what Dr Farmer was saying and, apart from that modest contribution to the public debate, my own research interest is directly in consumer affairs and current opinion over the grants from the NHS Executive. I think that the themes of that qualitative research are of interest and acceptability and the concept of "guinea pig" has not arisen, but I think there is a feeling of a contribution to the current debate where patients like feeling that their own doctors are sufficiently interested, and that it is not simply a nine-to-five humdrum general practice as they see it, so I think it has spin-offs for the individual, the researcher, the partners of that researcher and for the practice as a whole and extending the quality, there is a knock-on effect to the patients and they like it.

Lord Butterfield

381. I wonder whether the visits to general practice by research workers were, in your view, increasing. In a way in the past it really was very unusual for anyone to say, "We are going to take time off to work in a general practice". I wonder whether academic folk of all natures might not be coming to general practice, I will not say, pestering you, but presenting a bit of a visiting problem.

(Professor Jones) They are mostly welcome. There is no doubt that people are looking at the primary care and secondary care interface in rather a different way now and are looking at the different things that happen in general practice in a way that they did not before and also that a lot of research starting in hospital is beginning to look in the community as

24 January 1995]

PROFESSOR DENIS PEREIRA GRAY, DR WILLIAM McN STYLES,
 PROFESSOR ROGER JONES,
 DR ANDREW FARMER AND DR KIERAN SWEENEY

[Continued]

[Lord Butterfield *contd.*]

well as at the medical process and so there are a number of reasons why this should happen. We do think that some of our cancer patients can get over-researched and a number of practices I have been involved in have got a mechanism to flag up patients involved in research projects and to ensure they are not endlessly in receipt of questionnaires and semi-structured interviews and so on. On the whole, I think it is welcome and good for all parties.

Chairman

382. Is there any problem, Dr Farmer, arising from the geographical split between your practice which is some distance away from the parent medical school and the university or is this something which is readily overcome?

(Dr Farmer) The distance is not great. From our point of view, it is 15 miles and a half-hour car journey and that does present some difficulty. There are two main issues here. One is that if one is going to have a research practice, one does actually have to make sure that people in the practice stay enthused about it, but at the same time I feel that we need the links with the university department, and I think that is not insuperable. Taking half a day out a week and going and meeting people there is an opportunity to pursue particular issues. I think the other thing that I have found particularly useful are the electronic links. I am now set up with E-mail on my desk and I can talk back and forth with the people in the university department and carry on conversations on really a twice-daily basis, if I need to, about particular projects. That actually is one way that I keep going and that was the same with colleagues I have met in the States who swap papers back and forth. It is not a problem from that point of view.

Lord Perry of Walton

383. Could I ask whether you see any merit, assuming there were trainees immediately after their entry into the profession, in some of them being not in the university department of general practice but in your research practices? Would they in fact be able to ease the burden by doing some of it? As far as I can see, most of what you want is help in maintaining records and so on.

(Professor Gray) I think we would want to draw a distinction, my Lord Chairman, between the undertaking of research and the learning of the craft and essentially the College's recommendations for the research training fellowships immediately after vocational training is that they should be learning the skills and obtaining the higher degrees which have been useful in all other branches of medicine. To that extent, we think it is fairly important that these young doctors should be placed in close association with and under the aegis of the university department of general practice because at the end of the day they have got to get a university thesis under their belt. Afterwards we would hope that they would be ideally qualified to apply for research practices and to make good use of them.

(Professor Jones) It is an interesting point and I think one thing we need to think about, even if it is not in the terms of reference, is exactly what teaching

gives. We really see these academic practices as having a very important role in the expansion of community-based undergraduate teaching and clearly people who come into these training fellowships may want to make a career which involves the acquisition of teaching skills too. The idea of extended vocational training as an attractive career entry to general practice is being used in London as part of the manpower flexibility initiatives to improve the recruitment and retention of GPs in the city and certainly within that system, which I think will be well subscribed actually, we are using practices other than academic general practices for these people to do some of their work in, although they are still closely supervised. I would see them having a symbiotic relationship.

384. When I was teaching in medical school there were no other or very few departments of general practice. I do not know what the research which goes on in departments of general practice really is.

(Professor Jones) Shall I tell you about my own just as an example? There are two or three kinds of research, my Lord Chairman. We are interested I suppose, in a long tradition of general practice research, going back to John Fry, in describing the course of common diseases from a general practitioner viewpoint. The textbooks have all been written from another viewpoint and it is helpful to refresh that description. Secondly, we are interested in looking at various kinds of intervention in that process, screening, preventing disorders and treating them, and again from a GP viewpoint. We are looking within that at ways in which others than doctors, such as nurses, counsellors, other people working in primary care contribute to that process. We are looking more broadly at health services research and the ways that the health services are delivered and other ways of providing primary care within traditional general practice, the use of primary care centres in the city, for example. The kind of clinical conditions we are interested in particularly are mental health problems, control of hypertension, the control of asthma, diabetes, the common chronic disorders that affect us. Most of the departments whose work I am familiar with are approaching common clinical problems from this standpoint and using not just clinical researchers, but people involved in sociology and others to inform the work.

Lord Gregson

385. Just as an addendum, the thought occurs to me, does Care in the Community actually present an opportunity for more research within general practice because a lot of the mental problems of course are now in the community and not in the hospitals?

(Professor Jones) Yes, one of my projects which is currently funded from Tomlinson funding is to look at just that, to look at what the new challenges of providing primary care for mental health problems in inner London are. In a way, that is an example of something that is happening across the board, that as hospital stays get shorter, hospital beds get fewer, more and more has to happen outside them, and general practice is where that has to happen, and clearly this shifting of the focus of care across the

24 January 1995]

PROFESSOR DENIS PEREIRA GRAY, DR WILLIAM MCN STYLES,
 PROFESSOR ROGER JONES,
 DR ANDREW FARMER AND DR KIERAN SWEENEY

[Continued]

[Lord Gregson *contd.*]

interface from the hospital into the community raises all sorts of questions about the skills required, about the resources required to support clinical care of that kind and Care in the Community in relation to mental health is but one example of what is happening in a range of clinical conditions.

Chairman

386. Is it a requirement that all principals in research practices should also be recognised trainers for vocational training of trainees in general practice?

(*Professor Gray*) No, my Lord Chairman, it is not. The reason is a survey done by the College found that there were a number of general practitioners like, for example, Dr Maurice Stone at Leigh in Lancashire and others who have made considerable research contributions, but for personal reasons may or may not wish to attend training workshops to go to update the arrangements that trainers are now required to do and at the moment the College view is that in fact in the fullness of time we would like to see research and teaching come together as in all the other branches of medicine. At this particular point in time, the urgent need is to recognise general practitioners of outstanding research ability in general research practices and they should, therefore, be appointed on their research capability and research capacity even if some of them, the minority, are not actually trainers simultaneously.

387. In that case, it then follows that you are not aware of any significant conflict arising at the moment between practices involved in the training of trainees on the one hand, and undertaking research on the other?

(*Professor Gray*) I think the issue there is that in fact we feel that general practices are under immense pressure generally. This is largely a branch of medicine which has never had any SIFTR or non-SIFTR equivalent and the amount of work generally has increased substantially. Those practices which are taking on additional teaching and now research are going to be hard pressed and we are very clear that resources must move to support this additional work, so that we do believe that it does have to be funded by new money through the National Health Service. It is possible that Dr Sweeney may wish to emphasise that tension.

(*Dr Sweeney*) It is a tension in our own practice. We act as researchers and trainers and two things happen there. One is that there is a very acute legal responsibility to ensure that in one's absence, for example, while I am at this meeting, I have got a proper deputy to consult patients in the way that is appropriate and medically satisfactory. The second issue is splitting the time between the teaching and the preparation for the actual research. There are research deadlines and there are writing deadlines. Equally, there are trainees who have needs and preparation to be acknowledged also, so I think what makes it work is a general culture of acceptability and support. Gratefully, in our practice, all four of us have this commitment, but it creates quite a lot of balls to keep in the air.

388. Yes, I can see that. Of course you as a group, if I may say so, represent the interests of the Royal

College, on the one hand, and also of course the academic teachers in general practice on the other. Now, in the past there have been conflicts, have there not, between the role of the College, on the one hand, and, for instance, the General Medical Services Committee of the BMA on the other which has tended at times to have a somewhat different view of the future of general practice? It would seem from all that I have learned and read that those conflicts are probably things of the past. Would it be your view that there is now a much greater conveyance of opinion on the part of all of those representing general practice, its training role and its research role?

(*Dr Styles*) I think there is a much better relationship between the College and the General Medical Services Committee than there has been in the past. I think conflicts sometimes arise, particularly in relation to financial resources, if the General Medical Services Committee feel that we are straying into General Medical Services funding and money, and I think we are quite clear that the sort of developments that we are talking about, both in terms of education and in research, would be quite separate from those and the sort of money needed to create the infrastructure that we have been hearing about this morning would be quite separate from General Medical Services money. I think if we moved in that direction, we would have no problem with our General Medical Services Committee colleagues.

389. Is it possible that someone with a qualification other than membership of the Royal College of General Practitioners could become the head of a general practice, for instance, someone who had a university Masters degree or something of that nature?

(*Professor Gray*) The College believes at this particular point in time when it is initiating something quite new that it is sensible when the funding is from College members' subscriptions that it would seem courteous to the doctors who are paying for those fellowships to respect the professional qualifications they have developed. The issue of research skills is nothing of course to do with College membership, as such. It is not a professional qualification in the universities and we would hope in the future that the general practitioner research practices will have higher university degrees and membership and indeed fellowship of the College. We do have it as a condition at the moment that they should be members of the College and we would support that, but we have drawn the attention of the Committee to a very important development in the College which is that in 1989 it introduced a new category of fellowship, the only Royal College which awards its highest grade of membership to a rigorous, open, quality appraisal for the care of patients judged by its success against the published criteria. We see, as we said in our evidence, this very important quality assurance programme which runs simultaneously with our research development coming together so that by the end of this decade we would expect in our research practices there to be doctors who have both obtained a higher university degree by research thesis and who have fellowship by assessment and have

24 January 1995]

PROFESSOR DENIS PEREIRA GRAY, DR WILLIAM MCN STYLES,
 PROFESSOR ROGER JONES,
 DR ANDREW FARMER AND DR KIERAN SWEENEY

[Continued]

[Chairman *contd.*]

guaranteed the quality of care for patients by that route.

390. If your objective of having NHS-funded research practices does come about, you would see no objection to one of those being headed by somebody who was not necessarily a member, but who had a university higher degree?

(*Professor Gray*) It would obviously be for the NHS to decide the criteria for NHS practices. However, we would point out that there is a career development issue here which is that general practice, more than any other branch of medicine, has had a harder struggle to move up the higher professional career than indeed the membership and examination itself which was a prerequisite. It is, therefore, fairly important for the College to ensure that the rigorous discipline of obtaining higher degrees is actually inculcated in the next generation. If its leaders were to be appointed without that, a model would actually not be as favourable as one would hope because we think it is important for the whole future of general practitioners that they should have, and it is a policy of the College that they should have, the membership as indeed is the case in any other branch of medicine.

391. To what extent in the research projects of which you are aware do you employ or use the skills of people other than doctors, such as nurses, social scientists and other such individuals?

(*Professor Jones*) I think that is probably the model rather than the exception for research, certainly in the university departments. In my own department I have two sociologists, a psychologist and one or two nurses and many of the associates and assistants are also behavioral science graduates and there are probably as many in total of them as there are clinicians. Most of the questions we ask require that kind of input. Some of them are simply clinical trials, but some are more complicated than that and they involve human behaviour, beliefs and anxieties and so on, and so the multi-disciplinary approach is the exception rather than the rule, and indeed the Association of University Departments has a substantial non-medical membership of about 60 or 70 out of a total of 350 which again emphasises the importance of these people in research and general practice.

392. And in the present climate, supposing you wish to use the expertise available in a university department of social studies or a university department of psychology or of statistics, is this something which is usually freely given by the university or do you have to pay for it?

(*Professor Jones*) It is variable. It depends a bit on the configuration of the community-based and behavioral science departments in the university. There is a tendency nationally towards larger groupings of people with common interests and community-based behavioral and science-based research in which case, if there is reciprocal authorship and grant-sharing for authorships, then co-operation follows. Where there is clearer demarcation than that, we have to find a certain amount of money, as it were, which we need to pay for, say, statistical advice from the university computer and statistical departments if you are not

part of the same school or sub-group of the faculty. It is variable. Clearly a co-operative model has many advantages.

393. Are any of your research practices fund-holding and does the fund-holding mechanism, in your view, benefit the prospects of research or is it detrimental?

(*Professor Gray*) We do not have a policy either way and would appoint them on merit, regardless of that.

394. So it could do. Do you think the Culyer Report which stressed the importance of research in general practice is likely to be, as the Government have implemented it, helpful to you and your colleagues?

(*Professor Gray*) Broadly, we would like to be broadly supportive of the general thrust of the Culyer Report. We see this as a substantial rationalisation and generally one which we greatly welcome.

395. What did you mean in your evidence on Culyer saying that the recommendations may create "a perverse incentive for those providers most sensitive to the importance of R&D"?

(*Professor Gray*) This is a hospital issue, not primarily a general practice issue, but there are a number of hospital trusts and some commissioning authorities, and indeed you referred earlier to the fact that the Health Service funds academic appointments in a variety of ways and in a variety of places, but the implication of Culyer, as we read it, is that those trusts will be expected to declare that and the implication of Culyer is that the control and resource will move eventually to the R&D directorates on a regional basis. Now, it is at least possible that in fact those trusts who have been most supportive, NHS trusts that is, of academic posts, senior lectureships part-time and that sort of thing for consultant staff, may see that as less attractive if they feel they do not actually retain the control of the particular academic initiatives they wish to pursue.

Lord Gregson

396. It has always been important really. The National Health Service is in fact a bureaucracy and a pyramid, top-down in effect. Is there any provision for peer review at the regional level of allocation of research funds?

(*Professor Gray*) I think it depends on the particular approach of the regional directors, but certainly speaking for my own in the South & West, there is indeed peer review of research applications, and we would certainly support that and believe that public money should be spent on the basis of rigorously-reviewed applications.

(*Dr Farmer*) I could add to that that, for instance, the NHS R&D grants which are being put in at the moment are being peer-reviewed, but, for instance, before we were awarded the research project, I was being sent two or three of these to review them without any recognition that that was actually totally unfunded on my part and I did it into the late hours of the night because I thought it was worthwhile.

397. It sounds as if it depends on the regional directors' individual approach to it in effect.

24 January 1995]

PROFESSOR DENIS PEREIRA GRAY, DR WILLIAM MCN STYLES,
 PROFESSOR ROGER JONES,
 DR ANDREW FARMER AND DR KIERAN SWEENEY

[Continued]

[Lord Gregson *contd.*]

(*Professor Gray*) It is a little more than that. Professor Peckham, as the National Director, has, through his Committee, issued a number of statements valuing peer review. There is a very clear direction for regional directors to use peer review.

Chairman

398. Are you aware of a significant number of research projects in general practice being undertaken under the locally operated research schemes and what is your view about the continuation of that scheme when the regions disappear?

(*Professor Jones*) If I may, my Lord Chairman, in answer to Lord Gregson, I have two other comments really. One comment is that individual regions vary a lot, depending often on whom their R&D Director is, which one has to recognise. The other thing is that throughout the more recent exercise of the NHS R&D initiative, quite a lot of emphasis has been put on consultation in terms of setting priorities, which is the other side of the coin. It is one thing to say what needs to be researched and then decide on the application to be funded, but it is quite another thing to determine what the research priorities are. That is what the NHS strategy has tried to do. It is difficult to mount a broadly-based consultation exercise as a way of gathering evidence to determine the priorities but that is a strong feature of it. The operation of locally organised research schemes again varies tremendously and clearly adequate representation of general practitioners and other people working in primary care on Committees is important if general practice and primary care are to have access to these funds. The problem can be that it is difficult for one Committee to have the breadth of expertise and experience to assess comparably some of the work that is submitted to them. I think that is true also of other committees as well. I am not arguing for a special deal for general practice, but I do think that general practice projects sometimes have difficulty when they are reviewed by people who are most used to reviewing hospital research. I think that is changing and in some regions is not a problem, but clearly it is a problem in some places.

399. Thank you. You have suggested that the R&D budgets in the NHS should be separately classified in primary care on the one hand, and secondary and tertiary on the other. What would be the basis of that classification?

(*Professor Gray*) The first point is the old management adage, "If you can't measure it you can't manage it," and until there is some clarification and identification of what research is and what research spending is being funded in primary care, it is not actually possible to follow any policy through into practice. So we see this as a clarification. The first question is, broadly speaking, how much is being funded in primary care and, broadly speaking, how much is being funded in secondary care? That does not appear to be available. Certainly the College has not been able to identify that in any published NHS statistics at this time. We therefore commend it to your Committee, as a first step, in clarifying where the money is going at the present, so that it can be followed in the future.

400. Would you include within primary care, particularly in certain parts of the country, the work of Accident and Emergency Departments in hospitals?

(*Professor Gray*) There are very considerable difficulties in the precise definition of primary care and you have touched on one of them. We are here representing the College of General Practitioners, primarily concerned with general practice, but the College would, I am sure, be happy to advise you, your Committee, or the NHS R&D, on the precise definition.

401. Have you any evidence at all about the proportion of individuals who are cared for in Accident and Emergency Departments, as distinct from general practice?

(*Professor Jones*) It has been thrown into sharpish focus in south-east London lately. Guy's Casualty sees 60,000 a people a year. About a quarter of those probably could be looked after if a general practitioner was seeing them, without the need for there being secondary and tertiary facilities. Work from King's College Hospital has also indicated a similar proportion. Maybe one in five people use casualty as primary care. There is quite a lot of research work about the role of general practitioners in accident departments and evaluating other ways of providing primary care when casualty departments disappear.

Lord Gregson

402. There was some evidence given some time ago that the people who attend at the accident services could be dealt with through the general practitioner, and that there is a higher incidence in city centres often because of the homeless, of course, who have no general practitioner.

(*Professor Jones*) It is a combination of homelessness and mobile populations who have not had time to register. Then there is commuting which is big thing. A lot of people develop chest pains or rashes on the way in from Sevenoaks. Also, there is a culture which seems to exist around city centres that they do not want to bother their doctor at the weekend. This sounds like a cop-out for the general practitioner but it is a genuine approach by the local population, as a means of getting weekend and night-time emergency care.

Chairman

403. The MRC suggested to us that the initial screening of patients necessary for determining whether they should take part in a particular study may expose health problems that would not otherwise have been identified and so place additional demands on fundholders' budgets. Are you aware of this problem and is it one that, in your view, would be likely to discourage such general practitioners from taking part in research?

(*Professor Gray*) This is a highly technical one, as you say. The first thrust of our view is that this is a symptom of a service for which there is no current infrastructure support for research. These are the kinds of pressure points which develop when people are asked to do things and there is no NHS basis for

24 January 1995]

PROFESSOR DENIS PEREIRA GRAY, DR WILLIAM MCN STYLES,
 PROFESSOR ROGER JONES,
 DR ANDREW FARMER AND DR KIERAN SWEENEY

[Continued]

[Chairman *contd.*]

them. So our main answer is, in fact, that if an infrastructure research support were put in place, this kind of problem would diminish or go away. Having said that, the issue is actually addressed in the Culyer Committee, which states clearly that the second category of its proposed streams is that the consequential costs of research should be increasingly seen in the Health Service as part of the cost of research. If that logic is accepted, then a real additional cost to the Health Service, whether it arises in a fundholding or non-fundholding practice, should be borne by the research. There is a long tradition of research in the hospital service which is why teaching hospitals are more expensive than ordinary district hospitals. They do generate higher demands and they often do provide higher quality of care but they often get better results. It is a more expensive business.

Lord Perry of Walton

404. May I ask, what seems to me to be a fundamental question, about the help that you are really asking for in research practices? Is the help really for the Research Councils to provide—whether it is from the Medical or Social Science Research Councils—or is it for the NHS to provide, because it is a service? Is it service help you need primarily, or is it research help, because you could put an application in either way?

(*Professor Gray*) I think there are different perspectives, but essentially the position is that the Medical Research Council should fund research in general practice in the same way that it funds it in any other, and the contract costs should fully cover all the implications of the research. That is the first principle. But we understood that your terms of reference were, effectively, that you were reviewing research in the National Health Service and, in particular, Culyer—the very important Culyer Committee—which we welcome. The Culyer Committee is clearly stating that there should be a more level playing field and more availability for general practice to obtain funding through the National Health Service. Our position, therefore, is that it should be the same as any other branch of medicine. So we answer the question by saying that there ought to be NHS provision because there is NHS provision in any other branch of medicine, including other forms available to doctors in the hospital service. So it is a level playing field which we request.

Chairman

405. But until five or six years ago it was the case, in university research for example, that the Higher Education Funding Council and its predecessor, the UGC, were required to provide the facilities in a well-found department, with technical back-up, secretarial support, accommodation and all other overheads, and the MRC or the charities were expected to pay only the direct costs of research. Are you suggesting that the MRC and other bodies may continue to support general practice, but the NHS is not providing the infrastructure to allow that research to be carried out?

(*Professor Gray*) The central point is that the general practitioners are the only major part of the NHS which does not have the infrastructure support, so “yes” is the answer to the question. We do think the NHS itself should provide it. How would it do it? I think there are a number of ways and we are offering, for your consideration, research practices as one mechanism and training fellowships as another.

406. Of course you could imply that the infrastructure in most situations is provided by the research component of the research practice.

(*Professor Gray*) Indeed. There should be no double-counting, of course. If they are funded one way that should be taken into account.

407. So your view is that the NHS provision should be similar to that, provided it is funded by the Higher Education Council and other bodies in the universities and so on?

(*Professor Gray*) The Higher Education Funding Council is only concerned with university departments.

408. I appreciate that, yes.

(*Professor Gray*) Therefore, as far as the university departments are concerned—Professor Jones has spoken about this—we are also concerned that the wider practising profession will not necessarily be on the staff of university departments.

409. There has been an implication that the NHS is providing—and has provided for years—an infrastructure in the hospitals, comparable to that which the Higher Education Funding Council provides in universities.

(*Professor Gray*) And there have been specific payments like non-SIFTR and things of that kind which have been available.

(*Professor Jones*) May I make one comment in reply to Lord Perry's? Your point is that there is a distinction between providing the opportunities (the freedoms, if you like) to think about and do research, which is the infrastructure, and then getting research grants in open competition with anybody from wherever to do the research, because clearly the GP-trained researcher is not going to do all the interviews and fill in and analyse all the questionnaires. There are other requirements to doing research projects. It is opportunity that the infrastructure provides, but the researchers still have to show themselves capable of competing with others. I am not asking for a feather-bedded research career.

Lord Perry of Walton

410. It is very difficult to see what the research grant would be for. Nearly every discipline, other than general practice, has its own set of techniques which are unique to the discipline and the expenditures are, of course, very much concerned with laboratory exercises rather than written material. I cannot see what the basis for the research grant would be, apart from the service support which I can wholly see.

(*Professor Jones*) For example, supposing we were trying to find out how to provide appropriate services for a patient with a certain disease, from a changing primary care to a secondary care configuration? We

24 January 1995]

PROFESSOR DENIS PEREIRA GRAY, DR WILLIAM MCN STYLES,
 PROFESSOR ROGER JONES,
 DR ANDREW FARMER AND DR KIERAN SWEENEY

[Continued]

[Lord Perry of Walton *contd.*]

would have to find out perhaps the prevalence of the disease in the population; the proportion of people who had consulted general practitioners; the reason why they had consulted; and the reason why some were referred to hospitals. Supposing those were the research questions. To do that we would need to design epidemiological survey methods and post questionnaires in large numbers. We would need to put them on a computer and analyse them. People, perhaps, would have to go and interview selected people with the disease. We may need to interview doctors who were providing services. We may need to analyse referral patterns, or prescribing patterns, relating to hospital or general practice. The researching doctor could not do all this. He would require a research assistant or a research associate. This would be a graduate—probably in psychology or biology—or a nurse to do that work. So it is a people-intensive paradigm rather than a machinery one.

Lord Gregson

411. The Health Service is changing very rapidly, but the changes are beginning to create a situation, in effect, where you have got trusts running the hospitals, which are not very interested in the infrastructure to support research but are more interested in making sure that they meet their budgets from their point of view. I have a feeling that this is going to change considerably. Fundholding GPs are highly suspect down the corridor from here with the Public Accounts Committee and there is no doubt that the standard of auditing of the GP service will become much stricter—very much stricter, in fact. You only want one or two classical cock-ups for them to jump to their feet and demand to see the Auditor General straight away and so forth. So the whole thing is going to change. Is there any feeling that this is the situation which is developing?

(*Professor Gray*) I do not think the College has a policy for or against fundholding as such. The principle of rigorous accounting would be fully accepted in all forms of public money. What is new is the recent Executive letter from the NHS Executive stating that the savings from fundholdings from this coming April can be used, for the first time, to fund research. As far as that goes the College welcomes that.

Lord Butterfield

412. I wanted to go back to the point Lord Perry was raising about whether it is a fair charge on the Medical Research Council, or whether it is on one of the other Social Councils. It does seem to me that one of your problems in presenting your appeal for research is that although immense advantages have come from general practice—I am just thinking of all the funding of immunology that has occurred in the West Country—but basically Research Council Committees are looking for work which will present a publication of general application to humanity, whereas inevitably a lot of your research is going to be particular—perhaps even to your practice or your neck of the woods in your organisation—finding out about how you are going to manage asthma or whatever it may be. So I think you are going to have

to bear in mind that when we come to deal with this we have got to find a vehicle to encourage you, but it is going to be much closer to Health Services research than fundamental research. I am sure you realise that those in the laboratories are very concerned that more and more of this kind of research that you are doing is encroaching on what they see as their core budget. You will have to bear with us because we are going to have to wrestle with that problem. As an aside, it will not do you any harm in the research world if you point out that you are a new factor which is going to increase the demands on budgets in research, but you do not want to encroach on the hard-pressed laboratory boys. Now this leads me to a question, my Lord Chairman, which I would like to ask. Do you get any people coming over from America or Europe, full of interest, enthusiasm and enquiry—and respect—for the extraordinary advances that this country has made in general practice compared to everywhere, as far as I can see? I have just been incredibly impressed with the way in which you have taken care of the people in this country—very often doing it for love—£12 an hour or whatever it is. Do people come from Brussels, places like that, and stand astonished at what you have been able to achieve?

(*Professor Gray*) I do not know about the astonishment, Chairman, but the College has a very active international Committee.

(*Dr Styles*) I would like to reinforce this point. We do have a very active international Committee that is extending its work, through a series of fellowships, to help other countries to develop the sort of primary care system that we have; and, in particular, we have done a lot of work in the Middle East and we are doing a lot of work in countries which were formerly behind the Iron Curtain. In fact, looking at the volume of work that is coming in this direction, this is beginning to stretch us quite a lot. We are beginning to feel the pressure from this, and we are really going to have to look at how we are going to deal with it, which will be very selectively in the future. There is a whole raft of suggestions which have just come back from one of our fellows who has been visiting in Pakistan, Nepal and these kinds of countries who are looking to our sort of model of primary care and, of course, we are very keen to help.

Chairman

413. And, of course, serving as I did some years ago, on the Advisory Committee on Medical Training in Europe, we had an immense battle with the European Commission to try to get vocational training in general practice accepted in Europe as a mandatory requirement.

(*Dr Sweeney*) If I could just say, as a confirmatory point, the traffic is not all one-way. Dr Farmer and I were approached by a United States appointments board, inviting promising young professionals in primary care to go over there and learn with the Americans; also, for us to talk about primary care and development in the United States and maintain contacts at the highest level in primary care. I know Dr Farmer continues to do that and I remember Professor Thomas Inui at Harvard, with whom I

24 January 1995]

PROFESSOR DENIS PEREIRA GRAY, DR WILLIAM MCN STYLES,
 PROFESSOR ROGER JONES,
 DR ANDREW FARMER AND DR KIERAN SWEENEY

[Continued]

[Chairman *contd.*]

studied for seven or eight months at the University of Washington.

414. If you were to be totally dispassionate—not looking with your general practitioner's spectacles—at research in the National Health Service as a whole, what would be your comments about the present situation of research in this country in the NHS?

(Professor Gray) If I could, perhaps, interpose a further response to Lord Butterfield, about his point that a danger in general practice research is that it may be only about that particular practice, which may be quite small; and what your Committee may be interested in, the issues of wider concern to humanity. Lord Butterfield, himself, was concerned with the general practitioner from Wiltshire who was awarded by him the prize MD of the University of Cambridge for researching the relationship between unemployment and morbidity. That happened to be a particular factory which closed in one place but classically it is of a wider interest and, indeed, some of the research relating to unemployment and illness goes back to that study. There are a number of issues. Tudor Hart's inverse care law was created from one practice in Wales and is cited all round the world. I think it is possible for general practitioners to write messages which will be of international significance, even though their particular study may have been geographically limited.

415. Do you want to have a little more time to think about research in the NHS or would you like to comment, in general terms, how you see it?

(Professor Gray) Yes, we would.

(Professor Jones) My observations really are informed by involvement in the NHS R&D strategy, knowing what is going on in university departments and awareness of some other developments through friendships and colleagues. I suppose I am greatly encouraged by the awareness of the importance of the primary care health services research, and I am excited by the other end of the spectrum which is the molecular medical explosion that has taken place. I have good friends who work in that world, as well, and those seem to be the two strengths at the moment. The NHS research effort: in my own assessment, I still think there are problems about funding the community-based research for the reasons that Lord Butterfield has alluded to. I think there are problems about research skills and one of the difficulties about much of the call for research bids in the NHS R&D initiative, particularly in relation to Health Service research, is that there are not enough people with Health Service research skills to do that research, so that requires some long-term investment of which these research practices are clearly a part.

416. Are there any other comments?

(Professor Gray) I am not sure we can wholly take off our general practitioner's spectacles. We would have to say that at a time when the NHS Executive is saying that the public policy is to down-size hospitals and to transfer major clinical responsibilities into general practice—and major managerial responsibilities as well—that it becomes a crying necessity to upgrade the skills of those doctors who are carrying that load—and who will increasingly

carry it—so that the whole Health Service is, in the phrase of the NHS, a “primary care-led health service”. If that is to come, the doctors in the front line have to have their skills upgraded very sharply and the research capability has to be dramatically increased.

417. Looking beyond Culyer for a moment, one of its proposals is that, in future, the disbursement of the “R” component of SIFTR should be based in hospitals, in particular, on something comparable to the assessment exercise carried out by the Higher Education Funding Councils. In other words, those who have conducted the research of highest quality; those institutions where that research has been done; would ultimately be receiving a higher allocation of the “R” component than the other institutions where the achievements had been much lower. How would you see this kind of assessment exercise being mounted, in relation to research in general practice, if you are to receive a component of infrastructure funding?

(Professor Gray) Same principles, same standards.

418. I see, same principles, same standards. Clearly we would be unhappy, I believe, if there were to be any suggestion of duplication of the HCFC exercise, and it has been suggested to us very strongly from several quarters that the same mechanism should be used in the NHS as is used in the universities. That would have to be modified, would it not, for research practices, for example, which do not necessarily have a university standing. Are all of your research practices likely to be associated with a university department in some way?

(Professor Gray) It is optional at the moment; some are, some are not. But we would entirely accept that if there is to be a rigorous review of quality, then it must be appropriate to the subject of the field and it must include work outside hospitals. We have made that point in our evidence - even outside universities in some cases.

419. Thank you. When I was a member, as I often was for years, of Advisory Appointment Committees, I used to have a fairly standard question to ask applicants: what do you see as the major research achievements of the last ten years, and if you look at your crystal ball what do you see as being achieved in the next ten years? How would you answer that question in relation to research in the United Kingdom?

(Professor Gray) The major achievement in the last ten years has been the establishment of university departments which have begun to obtain critical mass. Until the last ten years, many of our university departments were almost a man and a boy. Now we are beginning to get departments which have a reasonable size. I think, for the first time, we have started to get substantial funding in the half million, million pound bracket, in a number of places, and we have started to get European funding of that order on merit, so those are the principal achievements. We have changed the culture from something where there was an anti-intellectualism in general practice alas, to a more neutral position, and it is the College's policy to change it further to make it positively

24 January 1995]

PROFESSOR DENIS PEREIRA GRAY, DR WILLIAM MCN STYLES,
 PROFESSOR ROGER JONES,
 DR ANDREW FARMER AND DR KIERAN SWEENEY

[Continued]

[Chairman *contd.*]

welcome. We have started the battle on evidence-based thinking which is a major challenge for our branch of the profession.

Lord Butterfield

420. May I add, they have not mentioned the fact that (I would guess) general practitioners were computerised and using computers far beyond what you would find in the hospital world. The hospital world has got into computers recently, but your basic supply of computerised information is remarkable.

(*Professor Gray*) I am most grateful for that reminder in the sense that we now have evidence, as Lord Butterfield says, that there are more general practitioners with desk-top computers than any other country and more than in the hospital service; and particularly with the registered list, this gives us a denominator which is very precious in research terms. We think there is a substantial advance in the last ten years and I am grateful for that reminder.

Chairman

421. We would expect your colleagues to be plugging-in to the information superhighway!

(*Professor Gray*) That is to come.

422. But leaving that principle and those general comments aside, what would you see as the major achievements in research, in the last ten years in general practice?

(*Professor Gray*) I think we would pick out Norman Beale's work on, for example, The relationship of living patterns and disease¹. Professor Jones may have some examples of disease. Then there is research on computing, which happens to be an interest in my own department, where with half a million from the European Union to develop research technology, we have been able to put medical records on a credit card, for example, which I am sure would be acceptable to patients. I think that kind of organisational research development is exciting. On the training side we have a greater number of general practitioners registered for a research thesis—M.Phil. and MD—than ever before and there is a major campaign to increase that. I will ask Professor Jones to list some of the diseases.

(*Professor Jones*) The difficulty in answering this question is that one side of one's brain is thinking about publications and the other side is grappling with the impact on professional behaviour. This is no more or no less true with general practice in that much of what appears in the literature has very little effect on what we do. I am trying hard to think of areas where there is some conjunction between the two. Probably in general practice in the last ten years, in terms of our understanding of the way patients function as people, we are taking a much more patient-centred view and, therefore, being able to admit a patient perspective to what we do. This is an achievement and the importance of that is recognised widely. We have also made some progress in simple things like therapeutics. I do believe that work in a range of conditions, which has taken place in general

practice, has had an impact on clinical care. I am quite sure we are much better, through research, at screening in general practice; and we have understood by critically examining evidence, as well as doing the original research, the importance that screening has. For example, colonic cancer is on the horizon, and already we are looking at systematic ways of ascertaining hypertension. I do think that over the last ten years we have also made some very important international contributions to the debate about providing health services. This is partly again descriptive and partly analytic. We have exported a model of general practice—clearly to be taken up in the United States now—based, again, on a critical review of both descriptive and analytic research work. It is a mish-mash of some of the things coming out of original general practice, and some very astute descriptions of what happens in general practice, that contributes to a change of thinking, rather than specific clinical topic research.

(*Dr Styles*) My contribution would be the developments we have made in recognising and managing depression in general practice. In the College we have been particularly effective in not only promoting the research in that area but also in disseminating the lessons learnt. We have appointed an Educational Fellow who has a network of fellows throughout the regions of the United Kingdom, whose responsibility is to promote some of the lessons that have been learned from research and the recognition of research, and the proper management of depression within the general practice. It is a very common condition and one hitherto we have not managed terribly well, and we are trying to do better.

Lord Perry of Walton

423. In what journals is the research published?

(*Professor Gray*) There are only ten journals internationally in the world which are for original practice research and which are recognised by *Index Medicus*. It is of considerable note that Professor Jones is the editor of one of those, *Family Practice*, and we are pleased that the *British Journal of General Practice* is the highest rated general practice journal in the world; and in the American rankings in the *Citation Index* it is ranked 19 among the general medical journals. It is one of the highest specialty journals anywhere. There is reasonable evidence that the British contribution is substantial in these ten journals. Four would be in Europe and two would be in the United Kingdom. So we would put Professor Jones' *Family Practice* and the *British Journal of General Practice* as the two most important British journals.

Chairman

424. They are all peer reviewed?

(*Professor Gray*) Yes, they are all peer reviewed.

425. We have heard something about your possible solutions to the problem, drawn to our attention by both Professor Peckham and the MRC, of allocating funds from the new NHS R&D Budget to individual GPs; about, perhaps, the funding of NHS general practices and funding of sessions for research work

¹Note from witness: Dr Beale's work was actually on the relationship between unemployment and morbidity.

24 January 1995]

PROFESSOR DENIS PEREIRA GRAY, DR WILLIAM MCN STYLES,
PROFESSOR ROGER JONES,
DR ANDREW FARMER AND DR KIERAN SWEENEY

[Continued]

[Chairman *contd.*]

by individual general practitioners. Are there any other suggestions you would care to make?

(*Professor Gray*) We will take it up with Professor Peckham and the MRC, but we have not heard about this being a serious problem. We do not see it need be, as you have said. We would just point out to the precedents that the MRC has helped to fund Dr Tudor Hart for many years. We have a number of general practitioners who have had direct funding from the MRC or from major charities. Dr Sweeney in this team has had major funding from the NHS Executive. So we do not think there are insuperable problems. Of course, the grant donor should be rigorously concerned about the ability of the person to do the research, the contract should be tightly controlled, and the research should be delivered, whether it is in hospital or general practice. But we do not think there is an insuperable problem here.

426. Who actually handles the contract? Who handles the money? In a university department, for instance—even in a teaching hospital—most of these contracts are handled by the universities. Who would handle yours? Would it be the Family Health Service Authority?

(*Professor Gray*) No, the practices are independent practices in the British system.

427. So your practice would do all the auditing and the handling of the finance?

(*Professor Gray*) Yes, indeed. That was the model that Dr Tudor Hart did with MRC funding.

Lord Gregson] The Audit Commission—

428. They would do the auditing, yes.

(*Professor Gray*) But we would say that that would be a considerable minority. I think it is the exception which proves the rule. The great bulk of these research contracts will be in association with university departments.

429. So it would be exceptional for it to come to general practice and, of course, the MRC does not underpin NHS infrastructure costings. It assumes direct costs. Is there anything you would like to add?

(*Professor Gray*) There is just one point which you raised in one of your questions to us, which is in the College's evidence, but I think we would just want to take the chance, as we leave, of stating the principle. This is the current exclusion of university general practitioners with salaried appointments from the Distinction Awards Scheme, which was in your earlier letter and not in the latest set. The College position is only concerned with those who are salaried, only concerned with those who have

contracts with universities and medical schools, whole-time or part-time; and simply, in fact, that it seems to the College an anomaly that these are the only doctors in the whole of medicine who are excluded when community dentists, post-graduate deans and even management can all be taken into consideration. We believe this is quite a serious disincentive which we would wish to draw to the attention of your Committee because it means that if a very able young research worker is working on boundaries—say, between psychiatry and general practice, or paediatrics and general practice—we have a very embarrassing career advice issue. If he wishes to research on that boundary, we have to tell him that his career opportunities, if he chooses to go into a department of psychiatry, that at the very top he could even double his income compared to becoming an internationally successful general practitioner researcher. That seems to us an awful thing for leaders in general practice to have to say to able young doctors. There is no historical justification for it. It is a severe disincentive and at a time when the National Health Service is talking about encouraging performance and rewarding good performance, it is an inappropriate policy to be continuing in the National Health Service.

430. Of course, the whole future of the Distinction Awards Scheme, following the Kendell Report, is now under consideration and review. Is it not, however, the case that whereas the College has recommended the extension of the Distinction Awards system to general practitioners, the GMS Committee of the BMA has been implacably opposed to it?

(*Professor Gray*) That is perfectly true, my Lord Chairman, but we are careful at the College to draw a distinction between the salaried component and the independent contractor services. As far as independent contractors are concerned, we have no *locus*. That is a matter for the BMA to discuss, the remuneration and parameters, as independent contractors. We are only speaking of those who have accepted salaried, whole-time or part-time employment in university or medical school, and only in respect to those salaried members do we see an issue of principle. Once a doctor accepts a salary, then he accepts the terms and conditions of service and it should be the same across all the branches of medicine.

Chairman] I see. Thank you very much. That is very helpful.

MINUTES OF EVIDENCE
TAKEN BEFORE

**THE SELECT COMMITTEE ON SCIENCE
AND TECHNOLOGY**

**SUB-COMMITTEE I MEDICAL RESEARCH AND
THE NHS REFORMS**

Tuesday 31 January 1995

NHS CENTRE FOR REVIEWS AND DISSEMINATION

Mr Trevor Sheldon

UK COCHRANE CENTRE

Dr Iain Chalmers

Printed pursuant to the Order of The House of Lords of 22nd November 1994

LONDON : HMSO

£5.80 net

TUESDAY 31 JANUARY 1995

Present:

Butterfield, L.	Perry of Walton, L.
Gregson, L.	Selborne, E.
McFarlane of Llandaff, B.	Walton of Detchant, L.
Nathan, L.	(Chairman)

Memorandum by Trevor Sheldon, Director NHS Centre for Reviews and Dissemination, and Iain Chalmers, Director UK Cochrane Centre

1. BACKGROUND

Over £35 billion of public money is invested in the NHS annually. The principal aim of this investment is the maintenance and improvement of the health of the population. This is to be achieved either by direct spending on health care interventions (including prevention, treatment, rehabilitation and palliation), or by investment in research and development to obtain new information on ways to improve the health of populations and individuals (including the relative effectiveness and cost-effectiveness of health care interventions.)

Since resources are finite it is important that they are used efficiently, both for delivery of care and for research. A precondition for pursuit of this efficiency is that existing information about the effectiveness and cost-effectiveness of health care interventions should be readily available to and used by decision makers in the NHS, and that plans for new research are based on a clear demonstration that the information required is not already either available or being actively sought in ongoing research.

Most lay people find it extraordinary that the information required to pursue this goal of efficiency has never been systematically assembled and made readily available, and that as a result the NHS and other health care systems are acquiescing in avoidable morbidity, mortality and misery, and resources for research are often being misdirected. The principal aim of the Information Systems Strategy of the NHS Research and Development Programme is to help to address this information gap by assembling information about the results of completed health research and research that is ongoing. The NHS Centre for Reviews and Dissemination (CRD) at the University of York and the UK Cochrane Centre (UKCC) in Oxford (which is also a constituent centre in the international Cochrane Collaboration) share responsibilities related to assembling information about the results of completed research. The Project Registers System assembles information about ongoing research.

The two principal activities of the two centres are: (a) to prepare and facilitate the preparation of systematic reviews of research assessing the effects of health care interventions; and (b) to disseminate the results of these and other systematic reviews to help promote the incorporation of evidence into policy and practice. The respective functions of the two centres are summarised in the attached table. More detailed information is provided in other attached documents (*not printed*).

2. WHY SYSTEMATIC REVIEWS?

There are several reasons why it is currently virtually impossible for practitioners, policy makers and patients to ensure that their decisions are based on accurate summaries of the research evidence available:

Volume and dispersion of the results of research: The results of health research are difficult to identify and access because they are scattered widely over many journals and other less formal sources, and over time. Reviewers who fail to search for research evidence sufficiently comprehensively may provide unnecessarily insecure and biased information.

Varying reliability of the primary research studies: Researchers have used a range of study designs, with varying degrees of reliability, sometimes dictated by the area studied. Furthermore, within each design type (randomised controlled trials, for example) the quality of studies varies depending on the care with which researchers have taken steps to avoid bias, confounding and imprecision. Unless reviewers have been trained to assess the quality of primary research evidence that they are examining, their reviews will be unreliable.

Inadequate capacity to synthesise the results of research: The diversity of types of study design and study quality, and the often conflicting results found in health research, mean that reviews must be carefully planned and executed to provide reliable and sensible results. In a systematic review, the research question must be defined clearly, as high a proportion as possible of all the relevant studies must be identified, the quality of the studies must be assessed, and the results of the studies must be synthesised in a statistically and clinically sensible way.

The methodological and other skills required to prepare reviews systematically are not trivial, and each of the stages noted above requires expertise. Because this expertise is not yet widely available, some people may

31 January 1995][Continued

be tempted to "cut corners" in preparing the many reviews required to guide urgent policy decisions in the NHS. Staff at the CRD and the UKCC believe that the risks associated with reviews which have not been prepared with due respect for scientific principles are unacceptable. The results of systematic reviews often differ importantly from those of less rigorous reviews (such as are traditionally found in textbook chapters and editorials). This serious problem is illustrated in the journal article attached (Antman et al. 1992), and will be discussed further in our oral presentation.

In summary, the NHS and its R & D programme cannot afford to be without the results of systematic reviews of existing research evidence.

3. DISSEMINATION OF RESULTS

Preparation of systematic reviews is only one element of the information activity. The NHS must be made aware of the results of carefully prepared reviews. These should be readily accessible, on a regular basis, so that practitioners, policy makers and patients will be helped to use research-based evidence in their day-to-day decisions.

Divergences between actual practice and optimal (evidence-based) practice can be costly in human and other respects. Examples include failure to use maternal steroids to reduce the risks of immaturity in premature babies, and failure to use thrombolysis and anti-platelet therapy in people suffering from acute myocardial infarction (heart attack) and other vascular disorders. We will elaborate on these problems in our presentation.

The development of practice patterns uninformed by relevant research evidence is not confined to the clinical arena, however. Indeed, it tends to be the rule in NHS management. Policy makers have been too ready to adopt the recommendations of 'management gurus' offering 'secure solutions'. The practices of total quality management (TQM) and the use of an 'internal market' to organise health care decisions, for example, were introduced with little regard to the evidence and in spite of their failure in other sectors or countries.

The UKCC and the CRD both play a role in disseminating the results of systematic reviews. On behalf of the international Cochrane Collaboration, the UKCC compiles and maintains the parent database from which the *Cochrane Database of Systematic Reviews* is derived. Technology permitting, this database will be demonstrated during our oral presentation. The CRD actively disseminates the results of significant reviews using a range of approaches, including the print and other media. It is also active in exploring and evaluating alternative ways of promoting the uptake of research information, including informing the public about information on effectiveness, continuing professional education, and use of opinion leaders. Some of these initiatives are outlined in the attached documents and illustrated in the accompanying leaflets.

4. FURTHER DEVELOPMENTS

The incentives implicit in the organisation and management of the NHS affect the uptake and use of reliable research evidence in health care policy and practice. The ability of R & D investments to enhance the efficiency of the NHS will be determined by the extent to which the NHS provides a "favourable environment" (incentives) for practising evidence-based care. At the moment there are a number of limiting factors which reduce the impact of the investment in R & D. The efficiency index used to monitor the performance of parts of the NHS, for example, provides a perverse incentive to increase activity largely independently of considerations relating to the cost-effectiveness of health care interventions. Similarly, the very substantial investment in medical and clinical audit has not been used systematically to identify ineffective practices and monitor the effects of attempts to control them. And the various waiting list initiatives have been pursued without sufficient attention to their ability to benefit patients, and regardless of their cost-effectiveness.

The Information Systems Strategy of the NHS R & D Programme is helping to lay the foundations for more informed decision making in the NHS and in health research. The information generated by the ISS, however, although essential, will not be sufficient to effect the changes that are required. The greater challenge is to ensure the the NHS is financed, organised and managed in all of the many ways that will help to promote evidence-based health care.

31 January 1995]

[Continued

UK Cochrane Centre, Oxford	FUNCTIONS <i>relevant to preparing, maintaining and disseminating systematic reviews of evidence about health care</i>	NHS Centre for Reviews and Dissemination, York
<i>Level of activity among core staff</i>		<i>Level of activity among core staff</i>
	Identifying NHS priorities for particular systematic reviews	+++
	Identifying systematic reviews already completed or being prepared (for inclusion in York Reviews Database)	+++
+++ (RCTs only)	Identifying primary studies for inclusion in systematic reviews	+ (Various designs)
	Preparing and commissioning systematic reviews for the NHS	+++
+++	Helping to establish Cochrane review groups to prepare and maintain systematic reviews	
	Helping individuals commissioned by the NHS to prepare systematic reviews	++
+++	Helping Cochrane reviewers to prepare and maintain systematic reviews	+
+++	Compiling and maintaining the Parent Database of Cochrane Reviews	
	Developing and maintaining a health economics database	++
	Providing information service about systematic reviews and reviewing	++
	Co-ordinating and preparing systematic reviews on dissemination and implementation	+++
	Disseminating and researching the dissemination of systematic reviews within the NHS	+++

Examination of witnesses

DR IAIN CHALMERS, Director of the UK Cochrane Centre (Oxford), and MR TREVOR SHELDON, Director of the NHS Centre for Reviews and Dissemination (University of York), were called in and examined.

Chairman

431. Good morning, Dr Chalmers and Mr Sheldon. We would like you first to speak briefly on the role and work of your respective organisations.

(Mr Sheldon) I will be starting. The organising theme really of both our presentations and in many ways the whole R&D programme within the NHS is to try to move the NHS towards evidence based health care. That is the theme around which we are going to talk, and about how best to shift the NHS more towards the delivery of evidence based health care on the grounds that that is the best way of maximising the benefits to the public. There are a number of examples where one can glean that perhaps that is not going on at the moment. There is evidence, for example, of variations in procedure rates by regions, for example. In big regions there should not be huge variations in practice. In the graph I am showing you now it shows the variations in the treatment rate for glue ear in the under-15s and there are significant variations across the regions which are not reflections of variations in the prevalence of the condition for which it is used which is evidence of uncertainty, evidence that perhaps clinical practice is determined often by the preferences of practitioners rather than the clinical evidence. A recent study carried out in the Trent

region here in co-operation with the Rand corporation in the United States looked at the appropriateness of open heart surgery, coronary artery bypass graft surgery, for people with heart disease, and coronary angiography which is a diagnostic tool for identifying people with severe heart disease. Their results, which were quite a worry, show that in the area of the heart surgery over 15 per cent of the procedures were unambiguously inappropriate and over 20 per cent of the angiography was unambiguously inappropriate. This was based on a synthesis of the evidence plus some consensus between experts in that very region. That was published in *The Lancet* in 1990. A systematic review of randomised control trials in the area of pregnancy and childbirth, which was originally published as effective care in pregnancy and childbirth, identified that something like 22 per cent of the interventions which they examined which had been researched were shown to do more harm than good. We do not have any evidence, of course, about how many of those are currently being used, these are interventions which were studied. These are all important and worrying features. So if we have this evidence we really want to know that clinicians are keeping up with the literature, surely people are aware of what works and what does not work? There was a very nice study from the United States which

31 January 1995]

DR IAIN CHALMERS AND MR TREVOR SHELDON

[Continued]

[Chairman *contd.*]

compared the evidence that was prevailing at any point in time with what the textbooks and editorials, what the clinical experts, were recommending to the clinical community in the area of thrombolysis, in the area of clot busting at the time of heart attack. What the graph on the left shows is when you have a dot on this side, of this vertical line, it shows that the treatment is more beneficial than no treatment. One can see over time, from about the mid-1970s, there was conclusive overwhelming evidence from randomised control trials that thrombolysis was beneficial and saved lives. More and more trials have been going on and that has just been confirmed more and more over time. From the mid-1970s it was pretty clear but the textbooks at that time were not even mentioning thrombolysis as a recommended treatment, or as even a possible treatment. Over time people started saying that it was experimental even when it had been confirmed in trials that it was beneficial. It was not really until the late 1980s that textbooks and editorials were recommending it as routine. In other words, there was quite a significant divergence between the evidence available and what people who were doing informal types of reviews, in textbooks and editorials, were recommending to the clinical community. Some people could interpret that as saying that over ten to 15 years a number of lives could have been saved if this more systematic reviewing of the clinical evidence had been carried out and made available to the clinical community. Really that systematic reviewing of the evidence and making it available to the community so that the practice can best reflect evidence is really what our two centres are about and what the information system strategy of the NHS is about. Even when we have evidence, even when the evidence is presented to people, we then have to ask to what extent does clinical practice reflect the evidence of trials? If we go back to the thrombolysis issue we find that even when studies have been published, even maybe when reviews have been carried out, clinical practice does not necessarily follow that best evidence. In the graph I am showing now one can see that there are major studies reporting in the mid-1980s up to the early 1990s showing the unambiguous benefit of thrombolysis and the take-up of that therapy having a long time lag, so there is a big delay between take-up and the research evidence. Partly that is reflecting the fact that the information might not be made available so easily to clinicians, but also that it is not automatic that clinicians will take it or count that evidence in their practice. Appropriate care is not automatic: health care professionals do not necessarily, by definition, provide the most appropriate care. Part of the job of the NHS in general and the R&D programme in particular is to try and help that happen. One of the areas that our Centre is particularly interested in is to try and provide high quality information on what works and to disseminate that in a way that changes behaviour. In the words of David Eddy from the United States: "The professionals place high value on developing the basic science of medicine, the biomedical side, it has not emphasised the process by which science is translated into practice." That is part of our task. So very briefly, focusing now on the NHS Centre for Reviews and Dissemination at the University of

York—and some literature has been sent to you in advance about that in our submission—our aim is to identify and review the results of good quality health research and to disseminate these findings actively to decision makers in the NHS and to consumers of health care. That is our principal aim. We do that in three or four ways. The first thing we do is to provide a regular source of summaries of research evidence either by carrying out reviews ourselves or commissioning others to do reviews or by identifying reviews that have already been carried out by other people which are of high quality. Obviously reviews of particular high quality Iain Chalmers is going to refer to later. Then the second task is to try and disseminate these results in a variety of ways to the NHS in ways that hopefully will try and influence decision makers, although it has got to be understood that that is an extremely difficult thing to do for a small centre but it is part of a process of dissemination, trying to encourage research based practice in the NHS by networking with health care professionals who are active in service development. We are also interested in evaluating what we are doing, evaluating different methods of changing practice. Finally, because time is short, I am sure in the questions you will be asking more about how we intend to disseminate things so I will leave that for the moment, the sorts of strategies that we will be using, the sorts of techniques that we will be using include working with people who are producing clinical practice guidelines; can we see how much purchasing can promote the incorporation of research evidence; how much does purchasing act as a lever for that; can we use patient leaflets to inform consumers about what is effective and use that as a lever to try and get change? You have got some examples of that in the pack that we sent you. What about incorporating evidence into audit? What about outreach or face to face methods, the academic alternative to drug representatives to go round and talk to clinicians and explain to them what the best evidence is? What about, for example, trying to link into opinion leader networks to try and change behaviour? A whole range of approaches which might work. Finally, we do not really know what different interventions do work to try and change behaviour. It is uncharted territory within the NHS because clinical autonomy has been the rule of the day, let people get on with things. We do not really know what interventions are the most successful. There has been a number of studies internationally, not many in the United Kingdom unfortunately, that have studied this and the University of York has been promoting, along with other universities around the world, a Cochrane Collaboration Review Group on Effective Professional Practice which will be systematically reviewing the evidence from good evaluations of different ways of trying to change professional behaviour. That is one of the ways that we are linking up with the United Kingdom Cochrane Centre and the International Cochrane Collaboration.

432. You mentioned at the end of your letter the issue of potential conflicts with the old principle of clinical freedom or clinical autonomy. There are, of course, very many fields such as that of thrombolysis where the evidence that has accumulated is extremely

31 January 1995]

DR IAIN CHALMERS AND MR TREVOR SHELDON

[Continued]

[Chairman *contd.*]

convincing; equally there are fields where disagreement and dispute between clinicians are still rife. For instance, despite many trials, you will find considerable disagreement about the best management of breast cancer between different experts. Even in my own field of neurology you will find considerable disagreement upon issues such as the early treatment of Parkinson's disease and the early management of epilepsy. Clearly there are circumstances where there is still room for considerable disagreement on the best treatment. No doubt you are taking account of these problems in your analysis?

(*Mr Sheldon*) Any good review can only be based on robust evidence.

433. Yes.

(*Mr Sheldon*) If there are gaps in the evidence the responsibility of a review is to identify those and to recommend the best ways to find answers to those questions. That is part of what the R&D programme is about. The reviews are not simply to say "This is what the evidence says you should be doing", it is also to say "This is where we do not have the evidence and this is where we need more research of this particular type to answer those questions". It helps to drive and focus the R&D programme.

Lord Perry of Walton

434. You said that you wanted to disseminate the information through NHS decision makers. Now, who are the NHS decision makers when it comes to applying any of these treatments? With one slide you showed the inappropriateness of coronary heart bypass. Who determines whether it is appropriate?

(*Mr Sheldon*) Let us go in order. Decision makers in the health service, well it would be tautological to say anyone who has a role in making decisions but that can go from management, clinicians across the whole range of disciplines, consumers and Government policy makers and so on. It is across the whole range. This is not just directed at clinicians, there is a lot of evidence that policy making as well ignores evidence in practice. This is not about having a go at docs, it is about trying to get some rationality into the provision of health care overall.

435. You are not meaning just the management.

(*Mr Sheldon*) No.

436. You do mean by the decision makers the clinicians and general practitioners.

(*Mr Sheldon*) Sure. They are the ones that make the most decisions on a day to day basis.

Lord Gregson

437. Can I just say that what you are showing on some of those graphs is typical of other disciplines. There is a lot of evidence that innovation ceases at the age of about 30. If you look at the graphs of the patents people take out, the graph is very well defined for fall off of innovation. There is a famous saying, of course, that if you are an experimental physicist you retire at 25 and there is a lot of evidence supporting that, that nobody has made a really new thought after quite a young age. There is a lot of parallel in this. There is a striking example in Japan at the

moment, of course, where they have failed miserably to keep up with the design of buildings relative to earthquakes. One building was opened last year, the theory of designing that building was 40 years old and it was known when they designed it it was not suitable for that particular purpose. This is not something which is strikingly confined to the health service, it is the whole pattern of innovation and acceptance of innovation.

(*Mr Sheldon*) I am not sure whether you are recommending that doctors should be retired at 25!

438. Doctors ought to be retired at the age of 40!

(*Mr Sheldon*) I do not think one is necessarily asking health care practitioners to be innovators, we are talking about how they adopt innovation.

439. It is a question of accepting change. A lot of work has been done on this, on accepting change, and the graph on thrombolysis is absolutely typical. The last 20 years of a consultant's life is absolutely useless as far as accepting change is concerned. That is true in every profession.

(*Mr Sheldon*) The greatest insights into issues of diffusion of innovation in health care and appropriateness comes from other areas like farming and industry, you are absolutely right about that, but the problem is do we accept that, do we accept that public money should be spent on delivering health care which is not optimal or that might even be harmful? How do we try and build a health service that deals with those problems?

440. One piece of evidence that does exist is that some countries require repeat driving tests every ten years and it is amazing how people fall off after about the age of 30 or 40 in being able to pass their test because they have not kept up with the information and are getting very slaphappy and slack in their application of what they are trying to do.

(*Mr Sheldon*) It is quite clear in answer to that area—I absolutely agree with you—that things like clinical audit, on which we spend millions and millions of pounds, have not really addressed these questions. This is part of what clinical audit should be about, saying how are people actually using that money, are they taking into account the best evidence, and if they are not then trying to devise ways of changing that. Of course, it might be, as you say, that you might do well with a system of accreditation but in many other areas, whether it be building or pilots, we would not accept people constructing buildings that fall down the next day; they might not be up to date but they are producing safe buildings. What we are worried about partly in the health service is also people being safe.

Chairman

441. There were, of course, substantial confidence limits in the very early thrombolysis data which made it difficult for people necessarily in the early stages to change their policy. I think there is evidence that consultants even beyond the age of 40 are in certain circumstances changing the pattern of their practice and have done so over many years. The other question I want to ask you is how will similar data to that which you have presented, for instance on glue ear, be accumulated when the regions are abolished?

31 January 1995]

DR IAIN CHALMERS AND MR TREVOR SHELDON

[Continued

[Chairman *contd.*]

(*Mr Sheldon*) Okay. First of all on confidence intervals, you are absolutely right that in the very early days the confidence intervals included the odds ratio of one, in other words it was not a statistically significant benefit, but as I was pointing out from really the early 1970s those confidence limits no longer included one, in other words they were highly statistically significant differences.

442. Point taken.

(*Mr Sheldon*) You are absolutely right, the accumulating evidence was convincing some 15 years before it was routinely adopted. In terms of collection of data, there is a national system of data collection, whether it be organised at a district level or regional level is really not that important for what I was showing because you can look at district variations as well. The level of aggregation of that data is not particularly a problem. What is a problem is the comprehensiveness and standard of that data collection which at the moment is really not good enough to do this sort of work on a routine basis across all conditions, it is much better, for example, in the United States.

Lord Butterfield] I just wanted to make the point that in fact when you have a new treatment it has to go into wide use and evaluation does take a little while. I do not know how long it takes for dissemination through coronary care units of the use of thrombolytics to reach out to practitioners generally but no doubt you have thought about that. I was working for a long time with burns and it was very interesting there how Leonard Colebrook introduced his ideas about keeping burns sterile but it took about ten years for this to percolate out and about generally. The other question, much more exciting to me having been concerned with health promotion is about persuading people to change their minds.

443. Absolutely. The point that you make about persuading providers, such as doctors, to change their pattern of practice pales into insignificance with trying to persuade patients to change their lifestyles.

(*Mr Sheldon*) There is a crucial difference, if I might interrupt, in that we are not paying the public to change their minds but we are paying doctors to provide the best practice.

Lord Butterfield] You will remember how well the doctors who smoked and had lunch together read Doll's work stuff and gave up smoking, whereas you poor nurses did not lunch together and learn as groups to do so.

Baroness McFarlane of Llandaff

444. We could not afford it!

(*Mr Sheldon*) Can I respond to when you were saying that diffusion can be slow.

Lord Butterfield

445. You can speed it, I can see that.

(*Mr Sheldon*) It is not just that. Often it is extremely quick even when it has not been evaluated. If you take, for example, the spread of laparoscopic surgery, there are graphs of the spread of that where an experiment was done on a pig one day and it was in 50 hospitals in the US practically the next day. The

diffusion curve for some procedures, even when they have not been subjected to much evaluation at all, can be very, very rapid.

Lord Gregson

446. There is a procedural reason for that, is there not, that you do not have to get it past the drugs people and so forth? Surgical techniques do not need all this assessment, in effect you can do it tomorrow if you like.

(*Mr Sheldon*) There are a number of issues you raise which are extremely important. I am talking about diffusion after licensing, I am not talking about the time it takes to get a licence. For example, Prozac and other selective serotonin reuptake inhibitors for depression have had an uptake rate which is very, very fast despite the fact that there is not convincing evidence of its cost-effectiveness relative to other anti-depressants. That is after licensing. There is an example of rapid diffusion partly led by the industry. There are other examples where beneficial cost-effective treatments have been very slow in their adoption and there are other reasons for that. We can come back to your other points in a second.

Lord Nathan

447. I found it extraordinary on one of your graphs the difference in timescale between those who are writing for journals and the conclusions you had reached. Is that because the information which you have is not available to those who are writing for the journals, or what is the reason for this?

(*Mr Sheldon*) Let me explain. This is not a study that I have carried out, it is a study from the United States by Antman and other people.

Chairman

448. One major factor, of course, speaking as someone who has seen at least three textbooks through about six editions, the problem is that between different editions there is usually a gap of five or six years which makes it difficult for textbooks to be absolutely up to date. Dr Chalmers, I think we must now give you the opportunity of giving your presentation.

(*Dr Chalmers*) Thank you. I would like to start with a personal note because I have found it quite helpful to measure things in terms of personal experience. When I was a clinician, I was fairly horrified to find out about four years after I qualified that I was actually killing my patients by using a technique which I had been advised to use in medical school. That was an extremely sobering experience: when you take on trust what your teachers have been telling you and you find through trying to apply it that your patients are suffering and dying unnecessarily. I imagine that most of the doctors here have been upset at some stage in their careers to find that something which they really believed in because they had read it in a textbook turned out not only not to be useful, but actually to be harmful. Once you have had that experience, you start to ask questions about where the information being delivered to us as practitioners comes from. I went into a research career after that, and because of my previous

31 January 1995]

DR IAIN CHALMERS AND MR TREVOR SHELDON

[Continued]

[Chairman contd.]

experience as a clinician I was particularly interested in research techniques to evaluate the effects of care, and that is where my debt to Archie Cochrane begins. One of the questions one faces as a researcher is which research questions have been shown with confidence to remain unanswered. The curious thing is that when you go to reviews to try to find out what people think is worth researching you find that there are no materials and methods sections of their reviews. You do not know whether to rely on them as a basis for choosing a research project. Now that I have given up being a researcher I am a patient and I am a relative of patients, I continue to ask the same sorts of questions. My father has increasing problems with his memory. What evidence can we turn to to make an informed choice about the treatments he might be offered? As a taxpayer, what reassurance do I have that the investment in research in this country is based on systematic reviews of the research evidence that has accumulated over the last 50 years? I do not find any basis for reassurance on any of those scores. So at all of these personal levels I have an interest in the NHS R&D Programme and what it is trying to achieve. Now I would like to introduce you to the findings of two of the most important papers I think have ever been published in medical journals. The first reported by Cynthia Mulrow, a physician who works in San Antonio, was a systematic review of the scientific quality of review articles published in the five major medical journals: *Annals of Internal Medicine*, *JAMA*, *New England Journal of Medicine*, *Lancet* and *BMJ*. Her data led her to the following conclusion: "Current medical reviews do not routinely use scientific methods to identify, assess and synthesize information". It is quite extraordinary that people who have shown that they are good scientists (because they write protocols for their primary research, they expect to conduct that research with respect to scientific principles and to submit it for publication describing what they have done) when asked to write a chapter for a textbook or a review article or an editorial often jettison scientific principles. It is very rare to find a textbook with a materials and methods section. How can one judge the validity of what people are writing in textbooks if you do not know the methods that they have used, first of all to look for relevant data in the first place, to control the biases that may lead them to select particular studies to move their conclusions in the directions in which they want to move them? What reassurance has the reader of the average textbook that people have done as thorough a job as these same people would have done in their primary research? Unfortunately, there is little reassurance available. As you saw from the Antman Study—which has been copied for you and presented in part by Trevor Sheldon, "because reviewers have not used scientific methods, advice on some lifesaving therapies has been delayed for more than a decade while other treatments have been recommended long after controlled research has shown them to be harmful". These researchers looked at American textbooks and review articles; but here is one from my home town, published in 1987. The statement that: "The clinical benefits of thrombolysis whether expressed as improved patient survival or preservation of left ventricular function remain to be

established" is lethal. I think the 2nd Edition of the *Oxford Textbook of Medicine* has sold about 50,000 or 60,000 copies. Goodness knows how many hundreds of thousands of people have read that information but that is what is available to us¹. When members of the public are exposed to the new phenomenon called evidence-based health care, they find it astonishing that we health professionals have let our house get into such a muddle. I have already referred to my debt to Archie Cochrane, with whom Professor Peters worked and had arguments in Cardiff. When Archie Cochrane was a medical officer in a prisoner of war camp, he received a leaflet urging him to defend his clinical freedom. His comment was that he would have willingly traded some of his clinical freedom for some reliable information about how to treat his patients. He was a remarkable man and very kind to young people asking awkward questions. He wrote a book in the early 1970s called *Effectiveness and Efficiency: Random Reflections on Health Services*. It takes about an evening to read and was reviewed widely—in *Le Monde* and the *Sunday Times*, for example. The book made a very simple point. It suggested that if we are going to have a health service that encourages sensible use of resources, we have to know what works. Some things quite obviously work. Hip replacements work: you do not need carefully controlled research to show that hip replacements work. Desibrillators work: putting a defibrillator on a heart that has gone into fibrillation will often start it up again and bring the dying person back to life: we do not need carefully controlled research to show that. But you do need research to find out which among alternative approaches to defibrillation are preferable, and or which among hip prostheses are superior. In those circumstances you need carefully controlled trials, randomised trials. About seven years after Archie Cochrane's book was published, he published the following statement in an essay that he wrote for the Office of Health Economics: "It is surely a great criticism of our profession that we have not organised a critical summary, by speciality or sub-speciality, adapted periodically, of all relevant randomised trials". He advocated the sort of thing which the Antman paper showed might have been done since 1960 with RCTS of thrombolytics. In the same essay Archie Cochrane considered which among the medical specialities was the least scientific. At that time it was a tussle between the cardiologists and the obstetricians. Because he was a physician he gave the wooden spoon to the obstetricians! My background is in obstetrics, so is my father's, so obviously this was quite a challenge. In responding to Archie Cochrane's challenge we accumulated some of the background experience upon which the Cochrane Collaboration has been based. Our pilot study started in the late 1970s, and is still on-going. It has aimed to systematically review all randomised controlled trials of care in pregnancy and childbirth. If you are going to be serious about the data collection for systematic reviews, you have to begin

¹ Note from witness: The sentence quoted is "lethal" only in the sense that it might discourage practitioners from administering thrombolysis, the clinical benefits of which were in fact established in 1983.

31 January 1995]

DR IAIN CHALMERS AND MR TREVOR SHELDON

[Continued]

[Chairman *contd.*]

by identifying as high a proportion as possible of all the methodologically trustworthy studies. This means randomised trials as a starting place, although one might move to other kinds of evidence if no trials are available and if it is felt that it is unlikely that trials ever will be available. The first phase of our data collection lasted about seven years. We searched 70 journals back to 1950, page by page, to look for relevant reports and we searched the National Library Of Medicine's electronic bibliographic database. Because some investigators do not publish the results of research which has disappointed them, we surveyed over 40,000 paediatricians and obstetricians around the world to try to flush out these unpublished studies. If one is doing a systematic review one has to try to give attention to controlling the biases that will result from incomplete data collection. Eventually we got up to date by about 1985 and that registry of potentially eligible studies has been kept up to date on a continuing basis since then. The second phase, which began in 1985, was to try to prepare systematic reviews of this accumulated evidence. That went on during 1985, 1986, 1987 and 1988 and many people around the world helped in that process, about one hundred people were involved. In 1989 they published a book, a thunderous great two volume monster, which attempted to give an assessment of what was known at that particular time. That book had a materials and methods section. It described the approach that had been taken to reviewing the evidence so that people could argue with the approach if they wanted to. On the way up today I was reading a very good critique of the chapter on the delivery of the placenta by a consumer representative, Gill Gyte. But at least the materials and methods used in the book were explicit. People knew what approaches had been taken by the reviewers. Because the book was so big and therefore so expensive we also produced a paperback summary, published the same year, with women using the maternity services in mind. As the Chairman has already said, textbooks get out of date, they are out of date at the time they are published. So the challenge was to try to keep these analyses up to date on a continuing basis. Beginning in 1989, an electronic journal of these reviews, updated as mistakes were identified and new evidence was forthcoming, began publication. That was called the *Oxford Database of Perinatal Trials*, it was published for four years between 1989 and the end of 1992. Oxford University Press charged an exorbitant amount of money to people who were subscribing to it and we felt that there were less expensive ways of making the information available to people in an updated form and these were implemented in 1993. The evidence accumulated as a result of this process has been used very widely. It has been used by the Royal College of Obstetricians and Gynaecologists to guide their audit procedures; it has been used by the House of Commons' Health Committee (the one that Nicholas Winterton used to Chair) in its look at the maternity services; it has been used by Baroness Cumberlege in her expert group on the maternity services; it has been used by researchers trying to decide how to rank priorities for new research; it has been used by lawyers trying to assess whether a particular case would be defensible; it has been used

by women themselves to argue for informed choice on the basis, perhaps, of differing values between women using the maternity services and people working in them. The work has been used very widely and has been translated into other languages as well. I think it was because it was a reasonably encouraging example of work being taken up and actually applied in practice that Michael Peckham felt that it would be worthwhile seeing whether the model could be extended. After taking advice from the Central Research and Development Committee, he decided to support the proposal to establish a centre to facilitate the growth of this kind of activity in other fields. The Cochrane Centre had as its opening statement Archie Cochrane's criticism that the medical profession's house was not in order. He could have applied it equally well to nursing, to physiotherapy or to speech therapy. All of the health professions are in a similar mess. His very simple message was so rapidly and widely accepted throughout the world that within a few months of the opening of the Cochrane Centre it became clear that this idea was going to command support on a very widespread basis. So the Centre rather quickly became the UK Cochrane Centre, one of eight Cochrane Centres around the world established so far, "UK" partly because it was one of eight but also because the Scottish Home and Health Department, the Northern Ireland Office and NHS Wales also wanted to help support its activity. This growth led to the emergence of the Cochrane Collaboration—an international network of individuals who have decided that they wish to prepare and maintain (for the rest of their careers) systematic reviews of the effects of health care. These people organise themselves in collaborative review groups. I will give you an example: the Stroke Group, has three editors, Professor Charles Warlow and Dr Peter Sandercock from Edinburgh and Dr Jan Van Gijn from Utrecht. They have a research fellow working with them, Carl Counsell, supported by the Wellcome Trust. They have a full-time administrator and some secretarial support based in the Department of Neurosciences Sciences in Edinburgh supported by the Scottish Chief Scientist. They have reviewers contributing to their work all over the world. One of the reasons why the Cochrane Stroke Group is international is that it has to be international. This is not purely a sentimental promotion of internationalism. It is because they reckon that possibly as much as 40 per cent of the evidence in which they are interested is published in Japanese. There is no particular reason to think that that evidence is irrelevant to people who suffer from or are at risk of suffering from a stroke in this country; so this evidence has to be sought and Japanese collaborators have to be found so that people can take advantage of it within this country and elsewhere. Here is the organisation of a collaborative review group: you have got this editorial team that I mentioned with specialist reviewers responsible for particular reviews and maintaining them thereafter who produce a module which then goes into the Cochrane Database of Systematic Reviews which although our plans to demonstrate this to you were frustrated I have certainly got it on a lap top computer and if at the end of the session anyone is interested in having a look at

31 January 1995]

DR IAIN CHALMERS AND MR TREVOR SHELDON

[Continued

[Chairman *contd.*]

what is available on it so far I would be very happy to show them that. These collaborative review groups are responsible for preparing and maintaining systematic reviews of the prevention, treatment and rehabilitation of defined health problems. I mention all of those dimensions because we do not want to encourage anyone to look just at treatment, which is something which medical people may be tempted to do too often, but to look at ways of prevention and also the challenge of rehabilitation and palliation sometimes too. They have to be international for the practical reasons that I mentioned. They have to be inter-disciplinary so that different perspectives on a particular problem are taken into account. Let us take incontinence for example, it could be a urological surgeon or a gynaecologist or a nurse or maybe a physiotherapist, and maybe other people I have not thought about, who have something to contribute to the way that a particular health problem can be considered. Collaborative Review Groups are responsible for identifying all of the studies relevant to their defined scope, and for producing modules for dissemination through the Cochrane Database of Systematic Reviews. There is another dimension within the Cochrane Collaboration which takes account of the fact that people's interests may not be in a particular health problem, but may be in an age group (like children, or elderly people) or in a setting of care (such as primary health care), or in a particular type or class of intervention (like surgery). It was mentioned earlier on that surgical interventions do not need evaluation. Lord Gregson was quite right that they do not need evaluation in the way that drugs do—to get licensed—but they certainly need evaluation. Surgery is quite as able to kill people or benefit people as are pills.

Lord Gregson

449. Two different views on the word "need" I feel.

(*Dr Chalmers*) Exactly right, yes. I just wanted to be very clear that you were using the word in the former sense. People within Cochrane fields, let us take primary health care, for example, have a responsibility for identifying studies relevant to the field. Chris Silagy, Professor of General Practice at Flinders University in Adelaide, is the field co-ordinator for the Cochrane Collaboration in Primary Health Care. He has organised a search of all the primary health care journals for relevant and reliable studies. He and his colleagues need to make sure that people working within the field of primary health care are properly represented in the problem focused groups that I have just described. For example, there are two general practitioners contributing to the pregnancy and childbirth group; and a Dutch general practitioner interested in the treatment of giardiasis is contributing to the parasitic diseases group. People in Cochrane Fields may want to compile specialised databases to serve the needs of the community with which they are associated, whether that be primary health care, nursing or whatever. The Cochrane Centres are part of an infrastructure being created to try to support all of this activity, and to co-ordinate it. There are currently eight centres. We have to try to make sure

that people who have expressed an interest in contributing to the Cochrane Collaboration are entered on to a register, with their specific interests recorded. Let us take epilepsy, which was mentioned earlier on. There is a very good initiative being led by Professor David Chadwick of Liverpool. He and colleagues from other countries had an extremely good exploratory meeting in Israel a couple of months ago. A number of people who had expressed an interest in epilepsy came to that meeting and they have decided to form a Cochrane Epilepsy Group. Something in which Trevor Sheldon's Centre is playing a very important part is maintaining registers of systematic reviews that are already available, and assessing their quality. One does not want to miss opportunities to stand on someone else's shoulders in doing this task. I reckon it is going to take us 20 years just to catch up with the evidence that is out there already. We have to make sure that we do not duplicate effort in that process. The Cochrane Collaboration is helping to establish a register of all randomised trials. We know that if you rely on MEDLINE you miss half of the studies that are out there. So not only are you not looking at all the evidence that you could be looking at, but you are almost certainly looking at a biased sample of it. Staff of the Cochrane centres help to establish the collaborative review groups and fields. Later on this week I will attend a meeting at St George's Hospital where a group of international contributors are considering forming an asthma group. At the end of the week, Professor David Sackett, who is chair of the whole Cochrane Collaboration, has convened a meeting with Professor Sleight involving people who are interested in heart disease. The Cochrane Centres have to make input to those meetings. The Centres also help to prepare protocols and develop software to help reviewers do what is almost always a much harder task than any of them had ever imagined before they have done their first systematic review. Policies and standards are obviously going to be important. The Collaboration promotes empirical research to improve the quality of reviews—for example, to find out whether the additional information obtained by basing reviews on individual patient data from all of the relevant trials is worth the investment of time and resources which that requires. This presentation has followed the brochure which has been circulated to you in advance. The last point that I want to make is stressed at the end of the brochure. The information generated by this process is, in my view, absolutely essential for decision makers in a whole variety of different places; but it is not sufficient to take good decisions. People have to take into account local needs or individual needs, local resources or individual resources; and how they square those in coming to decisions about priorities. The Cochrane Collaboration is an attempt to provide some of what is required to take better decisions within the health service; but I would want to end with this note of caution. Cochrane Reviews will not be a panacea. They cannot dictate clinical practice. But they will provide information that has to be taken into account in deciding what is the most appropriate policy or practice for an individual or community. Thank you.

31 January 1995]

Dr IAIN CHALMERS AND Mr TREVOR SHELDON

[Continued]

Chairman

450. You mentioned in epilepsy Professor David Chadwick's work with which I am totally familiar. He was once my senior registrar. Leaving that aside, there were articles recently in the *BMJ*, of which he wrote one, where he and another distinguished worker in the field of epilepsy came to diametrically opposed conclusions relating to the best form of treatment of epilepsy based upon what appeared to be quite convincingly performed clinical trials.

(*Dr Chalmers*) Could I respond to that?

451. Please.

(*Dr Chalmers*) He would be the first person to admit that there are no systematic reviews of clinical trials in epilepsy. So the first thing to find out is whether the differing opinions result from people choosing different trials to emphasize. What is required, and that is why he is now so keen to see a Cochrane Epilepsy Group emerge, is that there should be transparent and systematic reviews of the evidence that is available. There may then be disagreement about the methods used by the review, but hopefully that can reach a stable state at which one can say: "Well, the evidence says this". What the implications of the evidence are for practice requires a judgment. For example, to go back to the third stage of labour because I was reading about it on the way up, there is very clear evidence that giving prophylactic oxytocic drugs, uterus contracting drugs, at the time of the third stage reduces post partum haemorrhage. That does not necessarily mean that these drugs should be given routinely. If the circumstances are such that you can deal with a post partum haemorrhage promptly, then you may decide that it is not worthwhile giving the drug routinely. I think one has to distinguish between what the evidence says and what the evidence means.

452. Then of course there have been considerable disputes, have there not, internationally about the validity and indeed value of the use of prophylactic aspirin as a preventative against cardiac infarction?

(*Dr Chalmers*) Yes. I would look at it this way. If I was having transient cerebral ischaemic attacks I would have no doubt that—on the basis of the evidence available to me—that I would want to take low dose aspirin. But I am not going to start taking low dose aspirin now because, as a result of a recent brush with the health services, I know that I am at low risk of cardiovascular complications. Although I might reduce a very low absolute risk fractionally by going on low dose aspirin, it would not, in my view, be worth my while taking the drug. So you are quite right, and that is why I say that the evidence is essential, but that it is not sufficient for coming to informed decisions.

453. The point I was making is that there are many trials which have been carried out and many meta-analyses which have been performed on well conducted trials which give absolutely unequivocal findings in being able to recommend certain forms of treatment but there are other trials, apparently well conducted, which have come, quite often, to quite contradictory conclusions.

(*Dr Chalmers*) Some trials have been completely fabricated at one end of the spectrum.

454. Even looking recently at strokes, to which you referred, the trial carried out in the American Continent by James Toole and others on a multi-centre basis on whether or not it was right to carry out surgery in a post symptomatic carotid stenosis came to one conclusion, while a trial published last week in the *Lancet* by Charles Warlow and others came to quite a different conclusion.

(*Dr Chalmers*) I know of the studies to which you are referring, but not in detail. So this is a "non-neurological" assessment. I believe that a systematic review of these trials is likely to show that there is compatibility between the results of the trials. The issue concerns the value the intervention at a particular level of predicted absolute risk? In other words, if I have got a very slight carotid artery stenosis, is it actually worth my while going to my local surgeon to have a rebore without knowing what the surgeon's particular kill rate is. That is what I have to weigh up as a patient, is it worth it? With severe levels of stenosis, as with transient ischaemic attacks and aspirin, I would want to go for the operation, please.

455. Paradoxically Warlow did not reach that conclusion.

(*Dr Chalmers*) For the severe levels of stenosis I think he reached that conclusion.

Lord Gregson

456. If you had those two results in physics you would look for another factor that had not been identified. This does not seem to happen in the medical reviews that I see, people accept the trial and do not then enquire why the trial is different.

(*Dr Chalmers*) I think that one of the reasons there is variation is because of random variation and that is the advantage of showing confidence intervals. Another characteristic of systematic reviews, however, is that you can state prior hypotheses in the review protocol, stating in advance that you expect certain experiments to come out with qualitatively different results from other experiments.

457. There might even be another factor.

(*Dr Chalmers*) Yes, indeed.

458. Many times these different factors have been identified by different research results giving opposite results.

(*Dr Chalmers*) Yes absolutely.

459. That is what happens in physics.

(*Dr Chalmers*) Absolutely.

Lord Gregson] And you sometimes find you have been studying the wrong thing anyway!

Baroness McFarlane of Llandaff

460. Actually you mentioned David Sackett in your presentation, Dr Chalmers. We wondered about the Centre for Evidence-Based Medicine that we read about in the *New Scientist* and what kind of overlap that has with your work or how it relates to it?

(*Dr Chalmers*) First of all, it is important to make clear that this is another initiative for which the National Health Service's R&D Programme deserves credit. It has attracted a man from the other side of the Atlantic whose name is a byword for the sort of approach to evidence about the effects of care

31 January 1995]

DR IAIN CHALMERS AND MR TREVOR SHELTON

[Continued]

[Baroness McFarlane of Llandaff *contd.*]

which we have been discussing. After building what is probably the most best known department in the world looking at these things. Professor Sackett, at the age of about 50, decided to redo his residency training. So he went back to being a houseman, in essence, for two years, just to make sure that some of the ideas he had been developing worked in practice. For me, that anecdote probably says more about the man than any of his other attributes. He is a very important part of the "brain gain" to this country. He works within the Nuffield Department of Clinical Medicine which is also extremely important. Too often people like me and Trevor are on the touchlines of clinical practice and our credibility, quite rightly, is often called into question because of that. Professor Sackett is particularly interested in teaching and encouraging new approaches in under-graduate and post-graduate education within the NHS. In that sense his work is quite a long way downstream from the work in which Trevor and I are involved. We are trying to help the process of assembling the evidence upon which some of the teaching can be based confidently. Professor Sackett is involved in that process too. I mentioned that he is convening a meeting with Professor Sleight, which is bringing together people interested in forming a Cochrane heart disease group. I think the best way that I can describe the overlap between the NHS Centre for Evidence-Based Medicine and the work of the Cochrane Collaboration is that we are trying to help generate the evidence which Professor Sackett and others will use in practice in their efforts to educate young doctors and under-graduates, indeed old doctors as well, come to that!

Chairman

461. Mr Sheldon, with respect to the Effectiveness Bulletins, we have some examples of those but can you tell me how many do you publish; to whom do they go; and have you any measure of their impact on medical practice? What other strategies are you using to transfer research findings into practice?

(*Mr Sheldon*) The Effective Health Care Bulletins started as a project at the end of 1991, beginning of 1992, not commissioned by the R&D programme but by the Health Care Division of the NHS, the public health part of the Department of Health. It was quite soon after the NHS reforms and purchasers had been exhorted to really purchase on the basis of needs, purchase more cost-effective health care, and purchasers were really at a loss how to do that because they did not have the information on which to make those decisions. So the Department of Health decided to commission a series of Bulletins that would try and put together that evidence in the most systematic way that was possible within the timescale. Since then we have produced nine Bulletins and in the series there are another eight to follow. I think you have had a whole set sent to you or practically a whole set that was sent to you.

462. A considerable number.

(*Mr Sheldon*) They have ranged in topics. They were originally commissioned to be sent to 5,000 people who would be in purchasing, that was the principal aim. It was soon realised that was a bit of a crazy way to go about it and with so many other

people involved in decision making you cannot do that, you have to send it to providers, to FHSAs and so on, so it was up to 30,000. Now because of demand in the primary care area it is also sent to all GPs so it is nearly 60,000 of these that are distributed free within the NHS. It also goes to community health councils, local authorities, to the Royal Colleges, consumer groups, and so on. It goes out to quite a range of people although initially, as I say, it had quite a small distribution. In terms of impact it has been difficult to evaluate it, partly because there was no budget to formally evaluate it and the Department of Health did not do so. We did take two actions to try and get a clue as to what was going on. After the first couple we did a survey of purchasers to see whether they were getting to them, whether they were being read, whether they were being seen as credible and if there were examples of them being used. That survey was published, I should have actually included that in the pack, I can send you that if you are interested. It was quite optimistic. The people seemed to be quite thirsty for this type of information. It was seen particularly on the public health side, although less so on the management side—cultural differences—as something that was very useful and could potentially be implemented in practice. That really does not tell us whether they were going to use it, it is only a clue that this might have some effect. Before our Glue Ear Bulletin we commissioned a market research firm to do a telephone survey of all purchasers to enquire about a number of their purchasing activities but included amongst them their purchasing of operations for glue ear and ENT services as a whole.

463. Forgive me for interrupting but when you say "all purchasers" does that include fund holding GPs, for example?

(*Mr Sheldon*) No, I am sorry, all health authorities. At the time we were doing that GP fund holding really had not taken off in a big way.

Lord Gregson

464. Can you just define what you mean by "purchasing" in that case?

(*Mr Sheldon*) We are talking about health authorities contracting with hospitals to provide acute care.

465. Which is almost the same as fund holding in effect?

(*Mr Sheldon*) The majority of purchasing at the time that we were talking was carried out by health authorities.

Chairman

466. Health authorities and trusts?

(*Mr Sheldon*) No, the health authorities were the purchasers and the trusts were the providers.

Lord Gregson

467. Trusts came after the fund holding. Anyway, sorry, go on.

(*Mr Sheldon*) We did a telephone survey of health authorities to find out how they were contracting for glue ear procedures and ENT in general and whether

31 January 1995]

DR IAIN CHALMERS AND MR TREVOR SHELTON

[Continued]

[Lord Gregson *contd.*]

there were any quality criteria that pertained to what we knew would be coming out of the Bulletin but at the time they did not know. We decided then that two years on we would resurvey the health authorities to see whether the nature of their contracts had changed and try and get some sort of clue as to why it might have changed and that will be coming up in the next few months. What was interesting was that at the time only four per cent of health authorities contracted for glue ear procedures in any way separately from the rest of the ENT. So most of ear, nose and throat was purchased as just a block contract, there was no possible way that we could have included any quality standards within it. So we will be waiting to see. It is a problem because one cannot attribute change that easily unless one has some sort of control. That is why in the Informed Choice leaflets that you have seen, which have been piloted at the moment in three hospitals, our intention is to distribute that in a controlled way in the form of randomised control trials to see what influence this has on both the attitudes of consumers but also the activity of professionals. The other sort of evidence is really anecdotal. We have had a huge correspondence and information of an anecdotal kind from people who have said "We have used this. We have incorporated it into contracts". GPs have written—even the occasional letters from GPs—saying "This is the best information we have had from the Department of Health in all my career". We have also had "hate mail" from people who did not like the results of it which is maybe a clue to how deep they might be going. A number of people affected by this have also been writing in saying they do not agree. There has been quite a lot of correspondence in the *Lancet* and *BMJ* about what we have been producing. However, I have no absolute evidence that the Bulletins have had a significant impact on practice in the United Kingdom.

Earl of Selborne

468. I was going to ask how far we have got in the development of the NHS National Research Project Register and perhaps Mr Sheldon and Dr Chalmers could say what use they are making of this register?

(*Mr Sheldon*) We are part of the information system strategy, of which the third part is the project register system. I cannot give you an update as to how that is proceeding, I think you have to ask that of the R&D Division who are responsible for getting that going. I have used it in a number of ways. The way I have particularly used it is to identify people who have been commissioned to do reviews and we have followed up on that to identify exactly how they are doing those reviews. It has been rather useful for us to identify on-going reviews that have been commissioned either by the R&D programme or centrally commissioned and in some cases by other funding agencies. I must say though that at the time we received it a number of regions had not been entering data into it so it was a very partial selection of reviews that had been commissioned. We have also made a contribution and so has the United Kingdom Cochrane Centre on improving the structure of the database, in particular its methodological section. It is my understanding that it is being revamped and

upgraded and that in the near future a new version which will be much more comprehensive and complete will come on stream. For us it will be extremely useful to identify the research that is going on, particularly the reviews, so that we can make sure that we can help to promote quality in those reviews but also to make sure that we do not have unnecessary duplication.

Chairman

469. What about the clearing house in Leeds established in 1992? To whom do you think that has proved useful?

(*Mr Sheldon*) I think you would have to talk to Andrew Long who is the director of the centre at the Nuffield Institute and Dr Azim Lakhnai in the Department of Health. Again, it is not commissioned by the R&D programme, it is commissioned elsewhere. It has taken on a huge task to look at different outcome measures that people are using. I know it has run a number of workshops with health authorities and other groups. It has made contributions to the research community in terms of identifying different sorts of outcome measures that can be used in research. Really it is not part of my programme of work, but I can elaborate if you want more.

470. Anything to add on that, Dr Chalmers?

(*Dr Chalmers*) No.

Earl of Selborne

471. Can I just come back to Dr Chalmers about the National Research Project Register. Are you finding that the quality of the data is becoming more acceptable to you as a result of this register and as a result of the higher specifications required?

(*Dr Chalmers*) I am not a user of the project register in the same way that Trevor already is. One of my colleagues, Carol Lefebvre, sits on the steering group of the Project Registers System and our main concern has been to ensure that it will be possible to identify studies by their methodological design. I think it is absolutely essential information that is being assembled here to run a proper R&D programme. It is no accident that the Culyer Report gave emphasis to the importance of having an on-going census of what research is going on within the NHS, regardless of the source of funding. I think that it is high time that we were able to describe that activity more thoroughly than we are currently able to describe it. I believe that the clinical research community has no reason to feel complacent that the spectrum of research going on within the NHS is necessarily in the interests of the people using the NHS. So I look forward to the time when we are able to describe what is going on and to have the public commenting on what is going on within the research community. The Project Registers System will be a fundamental source of information for that process.

Chairman

472. We have had a good deal of evidence to suggest that for the proper performance of clinical trials in the treatment of both rare and common diseases in medicine there is a great advantage in

31 January 1995]

DR IAIN CHALMERS AND MR TREVOR SHELDON

[Continued]

[Chairman *contd.*]

capitalising upon the expertise of those in centres of excellence; and in the past there has been a regular recognition that patients have been referred on an extra-contractual basis often to such centres of excellence in order that such trials can be conducted. Now there is a lot of evidence coming to us suggesting that because of the internal market the extra-contractual and tertiary referrals, upon which some such trials for both rare and common diseases depend, are being eroded. Do you have any evidence on this?

(*Dr Chalmers*) I have no direct evidence but could I be allowed to make a comment on the question as it was put?

473. Yes.

(*Dr Chalmers*) I am drawing now on experience that I had while I was a researcher working at the National Perinatal Epidemiology Unit, so it is two or three years out of date. That centre developed an international reputation for having done more controlled trials involving multi-centre collaboration than any other similar centre in that field. It was our very strong impression that so-called centres of excellence were often some of the worst contributors to good multi-centre trials. They were sloppy in their data collection, and they were unenthusiastic about sharing glory with contributors in district general hospitals. What one found often was that the best contributors were working in district general hospitals. Their participation was an important and valued way of becoming involved in generating new knowledge. Centres of excellence can be very helpful in doing good trials, but they can also be a liability.

Lord Gregson

474. Touch of arrogance?

(*Dr Chalmers*) I think so, yes.

475. You talked about the dissemination of information. One thing that worries me about the whole of this subject is human knowledge is increasing on an exponential scale. Two subjects which have the shortest doubling time are medicine and information technology. Now in information technology the subject disciplines are split into multi-disciplines. There are now, on major projects of application, as many as seven or eight thousand separate sub-disciplines involved in creating extremely complex structures, not as complex as the human body. But I find that medicine is sticking to this definition of the disciplines whereas the amount of information being generated cannot possibly be applied by generalists or sub-generalists in those disciplines. Is there not a case for a much, much more divided specialisation? It is simply impossible to approach a subject as complex as the human body with the number of disciplines you have in medicine. How do you disseminate information that is complete for a discipline when the underlying factor is it is far too complex for that sort of treatment?

(*Mr Sheldon*) I think it raises two issues, if I might start on that, one is within my ability to comment on, the other one is not but that has never stopped me commenting. The first one is that the sort of work that the Cochrane Collaboration is doing, keeping up to date systematic reviews of the evidence, is actually

a way for clinicians to keep up to date in areas where you are getting an exponential explosion of information. That is part of the whole justification of this work, that people cannot keep up to date because the literature is expanding so rapidly.

476. Or simply cannot keep up to date.

(*Mr Sheldon*) That is partly because it is just published all over the place and often in sub-specialities, even when it is relevant to a generalist. So the reviews are an extremely important contribution to that because even sub-specialists cannot keep up to date with their specialities. The whole issue of sub-specialisation in medicine is a different debate and something I am actually quite worried about. You see it in the United States.

477. You see it in Japan.

(*Mr Sheldon*) Yes. My experience has been in the United States where you see sub-specialities developing and sub-sub-specialities. You even get jokes about somebody who gets involved in varicose veins: "Are you a specialist for the left leg or the right leg?" It can become absurd. At times I think some sub-specialisation is not a reflection really of the knowledge or the skill that is required but is part of carving out territory, it is part of the economics of private health care, particularly in the United States. I have been looking at the area of paediatric intensive care and other aspects of intensive care and there has been a lot of argument for having paediatric intensivists as opposed to general intensivists and so on and so forth. The evidence for the benefits of sub-sub-specialisation is in some areas very, very weak. I think we have to be careful that we do not assume because the information is expanding therefore we have to organise the sub-specialities. The economic implications in terms of service delivery can be quite worrying because you cannot share facilities, you start saying: "We want a separate ward, we have got to have a separate unit" and the implications of that could be huge without necessarily the benefits coming from it.

478. Due to the complexity and the amount of information that is now available it may be that is necessary to get the best medicine.

(*Mr Sheldon*) I am not convinced. One has to show it.

Lord Gregson] Unless you had sub-sub-sub-specialists you would never have got the Apollo Programme off the ground in America. There were 17,000 separate specialisations involved in the design of that moon shot. Drawing comparisons between the two the human body is infinitely more complex than that.

Chairman

479. Whilst some of the strictures that Dr Chalmers expressed a moment ago about the centres of excellence may well, I am sure, be totally justified, yet I think he would be the first to agree that the departments which for instance specialise in the treatment of a common disease, such as diabetes, may be by far the best departments, because of their experience and expertise, in which such trials and treatments and so on may be carried out. Similarly, the point he made before is absolutely right looking

31 January 1995]

DR IAIN CHALMERS AND MR TREVOR SHELTON

[Continued]

[Chairman *contd.*]

at surgical results in the treatment of carotid stenosis. So much depends on the expertise, the experience and the numbers of particular cases that are going to that surgeon. There is a similar case to be made in many, many fields for such centres of excellence.

(*Mr Sheldon*) Surely all of these are empirical questions, it is not a necessary thing.

480. There is quite convincing evidence from some of the major trials that some centres have much better results than others.

(*Mr Sheldon*) It is not always where you have the sub-specialists, that is the point I am making.

481. Not always, but sometimes. I would like to ask you about the relationship between the UK Cochrane Centre and the new post of NHS Director of Trials? Could we also follow that up by saying you are doing a remarkable job in that you are producing up to the moment 17 Bulletins but there are still a very large number of disorders in medicine where there is, as yet, no certainty as to what the best form of treatment or management may be. What is your ultimate objective? How far do you hope to extend your range of coverage across the field of medicine?

(*Dr Chalmers*) Taking first your question about Professor Stephen Holgate, who holds the new post of NHS Director of Trials. I have met with him twice so far, and I am very impressed. Ever since I first came across his work through reading *MRC News*, it became clear that he has a broad view of which research is worth doing. For example, although his interest is in the molecular biology of asthma he has also been looking at the social impact of asthma on families. He has said that this eclecticism has been strengthened during his time as Regional Director of Research and Development for the Wessex region, and that he is now able to see things from a variety of different perspectives. I think it is extremely healthy that someone who has been appointed to his position does have that broad view of research approaches. I think he also is convinced that if the right trials are going to be chosen, then we need scientifically defensible systematic reviews of what we know already, otherwise there will be investment in trials which are either less well designed than they might have been or, as is the case in several fields of which I am aware, completely unnecessary. I think that the relationship between his work and the work that we have been talking about is that to develop a coherent strategy for choosing which questions to address and which ways to design trials at a national level you have to depend on systematic reviews of what is known already.

482. Thank you. You hope to extend the coverage?

(*Mr Sheldon*) Yes. With respect to the work of the NHS Centre for Reviews and Dissemination, Effective Health Care Bulletins and other things that we will be putting out on effectiveness of care, our aim is not to be comprehensive, our aim is to try to be policy driven to answer questions that the NHS wants addressing in the shorter and medium term. That will necessarily be quite selective. We want to try and get information to where people are thinking, "should I purchase this?", "is this the best way to organise a service?", and try to answer those questions. Of necessity it will not be comprehensive.

Ultimately, in the long run, most probably after we have retired, the Cochrane reviews will hopefully have covered the majority of health care and the necessity for our sort of work will disappear.

Lord Perry of Walton

483. The information that you are producing from the systematic reviews is obviously going to have an effect, whether it is delayed or immediate, on the practice of medicine by the providers as well as on what the purchasers are going to ask the providers to do. That leads to an increasing element of direction. Do you think it is likely, through that, to inhibit curiosity-driven research which I agree is often a waste of time but sometimes is certainly not?

(*Dr Chalmers*) Personally I do not think it need inhibit it at all. I tried to illustrate the sort of curiosity that I have at the beginning of my talk by saying that I am curious about how I can help my father. The idea that "curiosity-driven" research is "blue sky research", rather than curiosity about whether or not particular treatments have anything to offer, encourages a dichotomy which I think is false and which is being encouraged by some people who want to do particular types of research. I do not see any reason why curiosity, from wherever it comes, should not be pursued. Depending on where your area of curiosity is, you will go to different types of funding agencies.

484. You started off at the very beginning by saying that you left the clinical field and went into research because you were unhappy about applying what the textbooks said you should apply.

(*Dr Chalmers*) No. I did not give a reason for leaving the clinical field. You have inferred a reason, which is not the reason by the way!

485. I went into research for exactly the same sorts of reasons. I wonder whether, in fact, by moving out and doing your systematic reviews you will actually replace what is in the textbooks with what is given by the NHS surveys, whether that will not become the information that will be applied by people unthinkingly?

(*Dr Chalmers*) Your concern is justified. That is why these reviews that we are talking about have to be assembled using materials and methods which are transparent, in other words, people have to know how they were developed. They also have to be readily available for criticism. One of the nice things about publishing electronically is that people can change their reviews in the light of valid criticism. If they publish on paper it gets bound in volumes and goes on to library shelves and gets referred to in its inaccurate form for years and years. One of the exciting things about electronic publishing is the possibility that it offers for developing an iterative process, involving both those preparing and maintaining the reviews and those reading the reviews, through which the reviews can be improved. For example, in high energy particle theory there is an electronic journal in which physicists are interacting in this way. When articles eventually do get into print in physics journals in this field, they are 18 months out of date. No-one is really interested in them any longer. I am quite certain that the

31 January 1995]

DR IAIN CHALMERS AND MR TREVOR SHELDON

[Continued]

[Lord Perry of Walton *contd.*]

economics of publishing are going to demand that paper printing of on-going reviews will become obsolete.

486. Could I ask about the effect of the increasing emphasis on health service research of this sort, which has obviously got enormous implications, whether it is likely to lead to a diversion of money away from basic research in the long run?

(*Mr Sheldon*) I was interested in the way the question was phrased because the question was phrased about efficiency gains to the NHS in the short term. I think good health services research will deliver efficiency gains to the NHS in the long term, and when we say to the NHS that is to patients. So I do not see that as a negative thing, I see that as positive. All research should ultimately yield gains to the NHS and to patients. There must be a pay back to research in the long run. Up to now there has been very, very little emphasis in the United Kingdom on how we deliver health services, the sorts of services that are delivered, the effectiveness and efficiency of those services. Most of the research in the health care area has most certainly been of a biomedical kind which obviously can yield paybacks but does not always. I think there has been a bias the other way to a considerable degree and the fact now that the R&D programme is promoting health services' research is a very, very positive step.

Chairman

487. You would accept that there are circumstances when today's discovery in basic laboratory science brings tomorrow's practical development in patient care. That may be a long term process.

(*Mr Sheldon*) Yes but we have just seen, for example, in the discussion of thrombolysis that even when that biomedicine had done its research it was not always being implemented. So there is no contradiction between good biomedical research and good health services research, the two are necessary for each other.

Lord Perry of Walton

488. There is no contradiction, I quite agree, the trouble is that there is only a limited budget and how is it going to be split?

(*Dr Chalmers*) Perhaps I can speak as someone who has spent 20 years as a health services researcher until I gave up recently. I am now in my fifties. I have never had anything other than a series of short term contracts. One of the reasons that that has been the situation is because of the frank neglect of the need to attract people into this type of research. Unless there is a bias in favour of this kind of research, people, for rather mundane reasons like mortgage repayments and so on, will choose to take safer routes, either in teaching or in more traditionally glamorous areas of research. I welcome the bias, which I think is extremely important and overdue. All sorts of people have their part to play in making sure that the bias is maintained and I would have thought that among the most important are lay people. Lay people should have the opportunity to analyse the content of the Project Registers System and assess the extent to

which the research agenda is distorted by perverse incentives, for example the bizarre idea that to achieve consultant status you have to have a list of publications of research. This is completely nonsensical. There are really perverse incentives operating within the research community at the moment. I would like the public to have the opportunity to see descriptions of what is going on, to comment on it, and to make their assessments of where the things are being done in their interests.

Chairman

489. I think one would have to say that we are anxious, no doubt, at the end of the day, that these two different forms of research as they are perceived by people in the research community, whether on the one side of the fence or the other, are to be partners in the long term.

(*Dr Chalmers*) Exactly.

490. Because, for instance, I speak now as someone who has been for 25 years chairman of a research charity, a charity which funds a great deal of research into things like muscular dystrophy where the firm belief of those lay people who support that charity, is that what they are looking for, at the moment, is gene therapy which they recognise is going to be based upon laboratory research. There are, of course, competing claims. Can I raise one other thing because it is perfectly clear that the outcome of the research in which you are engaged will, you hope, be influencing in the short and long term patterns of medical care by influence, exhortation and by dissemination of information. Do you ever envisage a time when such outcomes and such results might be used, for instance, by managers and the distributors of funds to withdraw funding for the purchase of particular patterns of health care? I think, for instance, you will know of the investigation in the United States some time ago on a huge multi-centre basis of the extra-cranial intra-cranial bypass where that looked to be a logical process based upon quite sensible criteria. Yet, in the end, the trials demonstrated that it was ineffective in improving the outcome of the condition and the purchasers of health care withdrew funding for it. Is that something you ever wish to see in this country?

(*Dr Chalmers*) Again I am now speaking as a patient. Lord Butterfield said something very important earlier on in the discussion about endoscopic surgery. He said, "It moves quickly if there is money in it". He is absolutely right, things do move quickly if there is money in them. What is rather extraordinary is that somehow we acquiesce in a situation where industry is investing millions and millions of pounds in trying to change people's behaviour, mainly the behaviour of providers but of purchasers as well. Yet there is an implicit assumption that with little gnat bites of pamphlets and exhortations we are going to provide information which counters the interests of industry (which are primarily and quite properly to serve shareholders). There is an enormous imbalance in the information reaching people. I am told, I do not know what the figure is in this country, that in Canada 8,000 dollars is spent every year for every doctor by the drug industry alone in trying to

31 January 1995]

DR IAIN CHALMERS AND MR TREVOR SHELDON

[Continued]

[Chairman *contd.*]

persuade them to change their practice in one way or another. That is a massive investment. Let us say it is only half that amount in this country. If there was a budget made available to the NHS to shift people's practice towards more evidence-based health care of that sort of order then we would be talking business, people would be really taking this issue seriously. My other comment is that I agree with you that external carotid-internal-carotid bypass surgery is no longer funded in the United States. I am very glad about that example. As a taxpayer I want to feel that if I have transient cerebral ischemic attacks I am more likely to be offered a carotid endarterectomy than an EC-IC bypass operation. Yes, I hope that people will use the various levers that are available to them to ensure that as a patient using the NHS, I am more likely to be offered something that is likely to work than something that is unlikely to work—as judged by the results of systematic reviews of the research evidence.

Lord Perry of Walton

491. I once examined a thesis of a chap who had done a survey of general practice practitioners in Scotland which examined where they got most of their information about treatment from. By far the majority came from representatives of drug firms. Do you think that your electronic availability will begin to change that?

(*Dr Chalmers*) The electronic availability is only part of the solution. The advantage of the electronic publishing is that you can keep things up to date more easily with it, but in terms of getting the information out to people it is not the answer by any means.

(*Mr Sheldon*) The evidence from research in this area shows that one needs a multiplicity of approaches to change behaviour and just giving people information, as we know in the health education area in terms of patients, does not change behaviour automatically. One needs to use continuing professional education, one needs to use incentives and even regulation which is really what you were implying. One cannot just rely on the professional's self-organisation to ensure that evidence is put into practice. What one has to make sure though is that one does not squeeze out the insights of professional judgment to which you were referring to earlier. Where there is clear evidence purchasers should be purchasing interventions that have been shown to be effective and not be purchasing things that have been shown to be ineffective. That is extremely important. There are lots of other ways which we are trying to experiment with and internationally one is trying to look at: informing patients because patients do determine the local demand for health care, they do help drive the system to an extent; using alternatives to drug reps. Why can health authorities or FHSAs not have their own system of getting information out of people by going and talking to GPs, by trying to target opinion leaders? There is a whole range of approaches including by using audit in a more targeted way. At the moment I would say the majority of audit money has been wasted, we should be using audit money to feed back: are people being effective; are they using

effective interventions and if they are not, why not? It is public money and it is extremely important it is spent properly. There are a number of mechanisms and the NHS has not got anywhere near thinking about how to use those. Part of the agenda for the health service's research is to explore the most cost-effective ways of getting that change.

Lord Butterfield

492. I wonder whether around the table we could accept the fact that we are going to have to recognise in research in the future that there are different kinds of people: there are your kinds of people who have got remarkable minds which aggregate things and see patterns and there are some other people who have got very imaginative research which will not fit into your plant at all. I think what the Chairman and some of us are worried about is that we do not want to lose those people from the medical field and give them to the spacemen! We need people, perhaps of our age, who are looking after the careers of the young people coming along, seeing what they are good at and encouraging them to stick at what they are good at and not try to be different.

(*Mr Sheldon*) We are not hoping that all medical researchers will do reviews. We want people to innovate. The problem, I think, has been that many people, for example doing MDs to become consultants, have been producing utter rubbish, I have to say that.

493. That was the price of admission to the poker game!

(*Mr Sheldon*) And actually have been set very bad examples about what is going on in research. We are in no way saying that everybody should be doing synthesis of the literature, that is most probably going to be a very small activity, although there are not enough people in the United Kingdom to do it at the moment that is true but that is not about detracting from primary research, in no way at all. The quality of the primary research is often revealed by doing systematic studies.

Lord Gregson] Some time ago this Committee did a study of education and training in new technology and we took a lot of evidence in California where there is a lot of work going on in the use of electronics for education. One of the striking things we found there was the use of electronic media and electronic techniques for updating doctors, even having expert systems in operating theatres. We were shown an operation—not my cup of tea—and the electronics were available. They had a complete expert system and the surgeon did not move until he had really looked at the box. I asked why this great surge of electronic transmission of information in the medical profession in California and they said: "If we do not the courts will take us to the cleaners". There is another driving force coming into this country and that is unless doctors are safe they are going to be bankrupt. The insurance companies will not go bankrupt, they will just stop insuring as they have done in the States. It is now, as you know, part of your policy statement that you keep up to date.

31 January 1995]

DR IAIN CHALMERS AND MR TREVOR SHELDON

[Continued

Chairman

494. Doctors in the NHS are indemnified by the NHS nowadays.

(*Mr Sheldon*) Can I raise three things briefly in response. Firstly in terms of the information technology. There are expert systems that are being developed in health care in Britain. Tim De Dombal in Leeds has produced one for abdominal pain and so on.

Lord Gregson

495. This was nine years ago.

(*Dr Chalmers*) His was more than a decade ago, in fact, one of the very first in the world.

(*Mr Sheldon*) Which has not actually been taken up by the profession which is sad even though it outperforms consultants. There are trials, for example, which I think the MRC has just agreed to fund about computerised prompts for GPs so that—

496. That was one of the things we saw actually.

(*Mr Sheldon*) That is beginning to come to Britain. What is important though is to evaluate how cost effective it is in trying to get change. That is the first point. You raised the issue of indemnity and I did not have a chance earlier to deal with it.

Chairman

497. That is a different issue entirely. I think we had better leave that.

(*Mr Sheldon*) It is about the NHS, you said about research going on in the NHS. I had a communication from Professor Baum which I thought I would communicate to you which was that actually some trialists are having a lot of difficulty in carrying out trials on well established drug treatments where the indemnity therefore does not come from the drug company and at the moment, trusts are often refusing permission for the trials to be carried out.

Lord Gregson

498. A trust has been refused insurance as well.

(*Mr Sheldon*) I think that is something that maybe the Committee wants to address because it is acting as a brake on some clinical trials in this area.

Chairman

499. We have gone over a lot of ground this morning and we are very grateful to you for your presentations and for answering our questions so very lucidly and effectively. Thank you for coming.

(*Dr Chalmers*) Thank you for inviting us.

MINUTES OF EVIDENCE
TAKEN BEFORE

**THE SELECT COMMITTEE ON SCIENCE
AND TECHNOLOGY**

(SUB-COMMITTEE I MEDICAL RESEARCH AND
THE NHS REFORMS)

Tuesday 31 January 1995

NHS R&D TASK FORCE

*Professor A J Culyer, Professor M Pearson, Professor I Allen,
Professor R Boyd and Mr John James*

Printed pursuant to the Order of the House of Lords of 22nd November 1994

LONDON : HMSO

£8.75 net

TUESDAY 31 JANUARY 1995

Present:

Butterfield, L.	Perry of Walton, L.
Jay of Paddington, B.	Selborne, E.
McFarlane of Llandaff, B.	Walton of Detchant, L.
Nathan, L.	(Chairman)
Perry of Southwark, B.	

Paper for the 140th Meeting of the 1942 Club, 20 January 1995, by Professor Tony Culyer**Supporting R&D in the NHS—some unresolved issues**

The Report of the Task Force (*Supporting R&D in the NHS*) was quite deliberately long on principle and short on detail. This was not merely due to the pressure of time, though four and a bit working months were a desperately short time for a problem as complex as that we were asked to tackle, but also something for which we consciously strove, partly because we felt that there was a real need to set out the basics of a new *framework* for supporting R&D in the NHS (both the R&D of the NHS's own programme and the service support provided by the NHS for the R&D of others) and partly because we realised that the final details of the arrangements eventually to be adopted would depend upon a lot of specific work in Professor Peckham's office and upon much further consultation. I know that we have disappointed some, more in what we did not say than in what we did, and I shall say something about these sins of omission later. But, after a hesitant start for a few months after the delivery of our Report on 30 April 1994, the backing that our Report has received both from the Secretary of State and the research community in general seems to have been sufficiently enthusiastic that it seems entirely proper to look ahead at some of the key issues that need urgent resolution in the reasonable confidence that the framework—at least for discussion—has now been set. I cannot cover all the issues but hope to address at least some of those that are likely to lie close to your hearts.

Let me begin by taking you back to our terms of reference. They were these:

taking into account the NHS reforms and the functions and manpower review; and building on existing work, the Task Force is asked to:

- (i) take stock of the current situation with regard to the conduct and support of R&D in the NHS, to establish the nature and extent of any problems, and in that light to consider whether it is appropriate to make recommendations; and, if it is;
- (ii) review the ways in which the NHS currently funds its own R&D and supports that funded by others;
- (iii) review the ways in which the NHS mechanisms for funding and supporting R&D promote and/or hinder the aims of the NHS R&D strategy and other Government policies relating to R&D in the NHS;
- (iv) advise on alternative funding and support mechanisms for R&D, including any necessary transitional measures; recognising that any new system will have to operate within available resources;

and to report to Ministers by 30 April 1994.

Our review and the conclusions from it are now well known and I do not propose to go through them in detail. It is important, however, to recognise that we were not charged with the task of considering the support of medical and health services research in its entirety, let alone that of the fundamental sciences, whether natural science or social science, on which all else depends, whose interface between the more applied sciences of medicine and health services research is absolutely essential, and whose various sources of support are highly complementary. I can think of some distinguished colleagues for whom it was a disappointment that we had so little to say on this subject. My immediate response to such disappointment is to say that one needs to go one step at a time and there was always the risk that in attempting to tackle further complex and potentially controversial issues we ran the risk of failing to address satisfactorily the important brief we were actually given.

But let me now address the issue I have just raised, though I am speaking, of course, for myself rather than on behalf of my Task Force colleagues.

BASIC WITH (NOT VERSUS) APPLIED SCIENCE

That the fruitful interplay between basic science and the more applied sciences is crucial can scarcely be emphasised enough. There are very few examples of major innovations in health care that do not have their roots in the ideas and experiments of scientists in core disciplines such as physics, biochemistry or economics.

31 January 1995]

[Continued

In fact, I can think of none. Sir Colin Dollery has put it rather well to me in the phrase "science can change the rules of the game, development may improve the standard of play by existing rules". I think by "development" he means specifically mission-oriented research and any that operates within a received scientific paradigm, which is not, of course, the concept of "service development" commonly understood in, say, trusts, which is characterised by the non-generalisability of its conclusions. Basic science, whether it be in physics or economics, is rarely targeted at any specific use. It is speculative and inventive, addressing questions generated by the imagination of the scientist in the search for greater generality, consistency and the solution of puzzles that may be absolutely fundamental. I am told that this sort of work is uncommon amongst clinical academics, who are more concerned with solving clinical problems using the paradigms, theories and experimental methods developed within the parent disciplines and adapting them appropriately to the problems in hand. They are trained in both the clinical investigative skills and the laboratory methods required to address such problems. *Mutatis mutandis* similar patterns can be observed in some at least of the social sciences which provide much of the core of health services research, with, for example, axiomatic structures of both behavioural theory and normative methods being developed by basic scientists, being then applied and developed over many years in empirical work (mainly statistical, such as econometric), and developed for specific purposes in health services research. Health services research sometimes involves the application of only medical science (as in clinical trials), sometimes the application of only social science (as in estimating demand equations for health care) and sometimes it involves both types of science (as in many cost-effectiveness studies of medical procedures). I do not want you to think that I implying any meritocratic ranking to the activities of colleagues working in these various fields; it seems plain to me that the fruits of science, beyond the sheer intellectual delight of puzzle solving and the invention of explanations for phenomena (which is a reward only to those engaged in it) inevitably depend upon a quite extended team of people having different skills and motivating passions. Moreover, that team is international, particularly, though not exclusively, at the more general levels at which science may be conducted.

However, the fruitful interaction between what I shall call, I hope without fear of being misunderstood, the constantly developing "science base" and its application along a continuum at the other end of which lies the practical implementation and use of procedures, is not linear. It is much better seen as a loop, and I conjecture the more of a loop it is made to be, the greater and more valuable the eventual fruits. While the ideas, concepts, theories and so on that are "applied" clearly in some sense have to precede the application, it does not follow that the organisation and support of research should follow in a compartmentalised or linear fashion. It seems clear that applied science, if it is applying anything rather than merely describing (I mean no offence to the taxonomists among you), must be applying, testing, or developing, the ideas and theories of basic science, and the invention of valid ways of doing this testing and application, whether laboratory-based in environmentally controlled experiments, or statistically-based and using the variation observed in nature and society, is a part of the imaginative excitement that draws many fine scientists into points along the continuum that are not "basic". It therefore follows that applied scientists have much to learn from basic scientists and that, given the dynamic nature of scientific development, means must be found for constant, or at least frequent, briefings and intellectual interaction, lest the more applied run down the intellectual capital which they learned as graduate students and become incompetent in comprehending, interpreting and applying the work of researchers in more basic science.

But a flow goes the other way too. While serendipity and curiosity have driven much research that has revolutionised medicine and health care, the needs of health policy, which are, of course, broader than those of NHS policy, ought also to inform the research agendas in the basic sciences, or at least that science which is one step nearer the applied end to the spectrum than the most abstract. At one level, that means that we need means of identifying better what the needs of health policy and the NHS for R&D really are (Professor Peckham has made revolutionary strides here in the past few years but much work still remains to be done, especially in enlisting purchasers' commitment to these processes). At another, it means that basic scientists must listen to the applied researchers to find out what holds them back from making even more effective contributions. In my own field, a good example of this sort of interaction has been the development of outcome measures, which is now quite a thriving industry involving applied researchers as well as engaging the interest of theorists in various social sciences. An area where we urgently need work if the fruits of science are more effectively to be brought to the advantage of ordinary people concerns the question of how to change the behaviour of practising doctors and other medical professionals in ways that are consistent with what good theory and good empirical research have shown to be effective. (My examples from sciences that are neither natural nor medical are deliberately chosen to illustrate the generality of what I am claiming.)

Two issues arise. One is largely for institutions, especially universities, which must find ways of ensuring that the dialogue in the scientific loop is developed and nurtured. The ways in which we organise research, the geography of our universities, and the managerial lead given by deans, pro-vice-chancellors and the like are all crucial here. I do not think that, in general, our various quality control systems, or external scrutiny methods, or internal forward planning mechanisms, typically pay much attention to these sorts of issue. They tend to be left to serendipity. The second is the question of who should pay for what. In the Task Force we were concerned only with the NHS's own R&D and its support for particular forms of applied research by others. This necessarily must include the hospital infrastructure that underpins the whole research endeavour, or at least part of it, partly because some of it is dependent on satisfactory patient flows of the right kind and

31 January 1995]

[Continued

partly because research activity is not easily, or sensibly, unpicked into parcels each with its own separate support structure. Much of the structure is shared. Moreover, there is also a sharing with the teaching function, especially post-graduate teaching. I remember well being instructed by my Vice-Chancellor on one occasion to be more selective in the allocation of departmental teaching duties so that the best researchers had less teaching. But apart from the fact that many of my best teachers were also my best researchers, the best researchers refused to forgo most of their teaching, especially post-graduate teaching. They, not surprisingly, saw the training of the next generation of researchers as one of the principal tasks. Moreover, they all found that teaching, even at quite elementary levels, was one of the sources of inspiration for good research ideas. All this has also been my own experience as a teacher and researcher.

I have gone on at some length about this because it has important implications. One is the undesirability of creating walls between researchers within institutions. Another is the undesirability of creating walls between teachers and researchers (quite apart from the personal tensions and jealousies that such policies, pressed too far, would generate). Another relates to funding. Before elaborating, let me digress with some comments on SIFTR.

Although there was a common view that the R of SIFTR might have amounted to about 25 per cent of the total, other voices could be heard suggesting that the T was 25 per cent (I suppose this might have been the angle of one seeking to maximise the amount of ring-fenced research money). It also seems to have been implied by some that, because the real rise in SIFT at the time R was added to it was only about 2 per cent, 2 per cent was the appropriate share of R (such might be the angle of one seeking to retain as much as possible within his or her institution). Not surprisingly, the Department of Health, in seeking to advise ministers on the appropriate division of SIFTR into its T and R components, conducted some multivariate econometric analysis. Its results were not, I am told, very helpful (though I should add that I was not one of the researchers doing this work, not have I had access—or sought it—to the work). Now, my view is that exercises such as these are fundamentally misdirected, and a range of “guesstimates” of R between 2 per cent and 75 per cent is only to be expected. Let us take an analogy. Consider a sheep farmer producing sheep meat and wool. Some variation in the quality and quantity of meat and wool might be possible in the short term by, say, varying the diet of the animals but, short of selective breeding, or mixing breeds in one’s stock, meat and wool are produced in pretty fixed proportions and, to all intents and purposes, jointly. It makes no sense to ask “is the fodder the cost of the wool or the cost of the meat?” By variations in feeding one might be able to estimate what the marginal cost (in fodder) of more meat, or better, or more wool, or better, is. But that is *marginal* cost and not the same as apportioning the *total* cost between the meat and the wool. I think much the same is true of teaching and research, and also of different types of research of the sort alluded to before. The proportions may not be strictly fixed, but they are variable only within fairly strict limits in centres of research excellence and of post-graduate education. So I conclude that it is not sensible to seek to separate the *total* costs of teaching and research, nor of types of research, where so much is complementary and mutually reinforcing. So what *should* one do? The sheep market can give us some clues. The approximate fixity of the proportions of meat and wool produced, and the impossibility of separating the total cost of rearing sheep into the costs of wool and the costs of meat, do not prevent each commanding its own price. The prices are determined by the interaction of the costs of rearing sheep and the demand for the various sheep products (plus, of course, much meddling in the form of the CAP!). In our case, what we have needed to resolve our puzzle is a revelation of the demand for teaching and research. This is not so much a matter for markets to determine as for the public sector funders, who are our principal demanders in the sense that they determine what R and what T shall be purchased (with various degrees of precision in the identification of the “product” being purchased). And this, of course, is what happened in the case of SIFTR. In the end, a public judgment by the accountable minister had to determine what the split between T and R should be.

Under the new arrangements proposed by the Task Force, we need to develop this sort of approach further. Policy towards our major centres of training and research needs to recognise both the mutual complementarity of the activity and that much of the infrastructure supports *both*. Within the R&D field, the same applies *a fortiori*.

The NHS’s R&D strategy is focused chiefly on health services research of the sorts I have already described. The new funding stream will add to this the R of SIFTR and the special research funding of the London postgraduate teaching hospitals. In the allocation of this matter, it will be essential to recognise the fact of complementarity between T and R, and that much of the infrastructure supports both. It will also be necessary to recognise that the research infrastructure also supports a wide variety of R&D activity, most of it not in fact the NHS’s own programme.

In emphasising the different sorts of criteria that will need to be borne in mind in allocating infrastructure support (what we called “facilities support”) and the NHS service costs of research on the one hand, and support for projects and programmes on the other, I do not wish it to be thought that I am suggesting that the NHS R&D strategy has been short term, and narrowly utilitarian. It does seem to me that a great deal has been gained from sharpening the focus of NHS R&D, but it is worth reminding ourselves that the R&D strategy of the NHS is far from *exclusively* short term and immediately utilitarian. For example, it has long supported fundamental research in outcome assessment. It is funding a set of projects on methodological topics. It has recently set up the Manchester-based research centre in primary care with a long term contract.

31 January 1995]

[Continued]

The usual way in which R&D has been commissioned has been by inviting tenders for somewhat generally defined topic areas which afford researchers an opportunity for developing or piggy-backing their own research priorities on to those of the strategy. Regions have often supported the imaginative establishment of new research centres and specific academic posts having very general briefs that satisfy the most jealous guardians of the principle of academic freedom. So let us not dismiss the R&D strategy of the NHS for what it is not.

It is also clear that some scientific concentrations combining points along the scientific spectrum from basic to applied benefit from being very large indeed and in such cases, which have usually been developed with the combined support of the Funding Council, the NHS, the MRC and one or more major charities such as the Wellcome, such collaboration is essential and highly beneficial, provided the internal management plays its role appropriately. Obvious examples of such centres are the John Radcliffe at Oxford, the Hammersmith in London, UCL, Addenbrookes in Cambridge, and the Edinburgh Royal Infirmary. They should not, of course, be supported simply because they are there and regardless of the outcome of on-going scrutiny. Nor should the emergence of other centres be prevented simply to protect those that are established but unable to compete in open competition. Moreover, a very large scale is not always either necessary or desirable. One of the emphases of the Task Force's report was that support should focus more in the future on individuals and teams and not be solely institutional, the latter being justified only when many individuals and teams worth supporting were all members of the same institution or a set of collaborating institutions. I should also point out that many of these centres, including those I have mentioned, have been much less successful at developing the multi-disciplinary health services research arm that would fully complement their clinical and basic natural science strength. Indeed I doubt whether some have tried very hard. Further, I am not aware that these institutions have made serious attempts to extend their research very significantly into the community or train cadres of researchers of the first rank capable of doing it. (I am not suggesting that every institution, or indeed any single one, ought to invest across the whole spectrum; I am merely observing how few in London have invested in non-clinical health services research.)

I conclude that *partnership* in research (and teaching) support for major centres having many specialist disciplines and operating along substantial lengths of the spectrum from basic to applied is essential and should be furthered. This is not to say that the separation of the R from SIFTR was ill-advised. On the contrary, the need for much greater clarity and more careful targeting was a recurring theme in the evidence the Task Force received. It seems to me that there are four major interested parties with stakes in this matter. On the research sponsoring side they are the NHS R&D Directorate, the Higher Education Funding Council, the research councils, especially the MRC, and the major charities. On the other side is the research and training community, especially the universities. What we seem to have lacked in the past is a formal mechanism that would enable issues of the sort I have raised (who should be supporting what, on what scale, by what criteria and in what kind of partnership?) to be fully debated and a broad policy agreed between them. The Forum, which was the first recommendation of the Task Force, is just such a body (a kind of comprehensive Research Liaison Group), perhaps with a working party supplemented where necessary with members representing other interests, to consider the matter. I hope Professor Peckham will make this an early item for the Forum, whose terms of reference were announced just before Christmas and whose members are in the process of being selected:

1. TO ADVISE THE DIRECTOR OF R&D, AND THROUGH DRD THE SECRETARY OF STATE FOR HEALTH, ON:
 - (i) current national and international strategic issues relating to R&D of importance to the NHS;
 - (ii) advances in science and technology which may impact on health;
 - (iii) technology transfer, covering links between basic science, applied research and health services;
 - (iv) the development of coordinated systems for information derived from and about research;
 - (v) the capacity, and ways to increase the capacity, for undertaking R&D, including health services research, needed by the NHS;
 - (vi) any other matters relating to R&D remitted to the forum by the DRD.
2. WITH A VIEW TO SETTING A STRATEGIC FRAMEWORK FOR THE CRDC, TO ADVISE THE DRD, AND THROUGH DRD THE NHS EXECUTIVE BOARD, ON:
 - (i) the overall pattern of funding for R&D, and the plans and priorities of individual research funding agencies;
 - (ii) the needs for NHS support for externally sponsored R&D within the NHS;
 - (iii) progress on the establishment and operation of new systems for funding and supporting R&D in the NHS.

*31 January 1995]**[Continued]**Facilities support*

The Task Force recommended that future financial support from the "single funding stream" should take three forms and, in addition, that the R&D Information Strategy, with its emphasis on dissemination of research results and the promotion of their uptake, be supported and that research capacity be further investigated and supported. The three forms of financial support were the direct and indirect costs of research projects and programmes, the "excess" service costs of approved peer-reviewed non-commercial research, and support for research facilities in trusts and other NHS research providers.

Facilities support is intended to cover the costs of maintaining or creating particular research facilities and staff which enable R&D projects to take place but which cannot reasonably be attributed to a specific project or programme. We envisaged that some programmes would themselves entail facilities support which would be embodied in the contract for such programmes, and this meant, of course, that the future system had to guard against the possibility of double counting in the form of supporting any particular activity twice over. I have already emphasised that facilities funding for NHS R&D needs to be considered alongside the other R&D and teaching activity of major centres.

One of the issues that has cropped up in subsequent discussions I have had with a variety of people, and which the Task Force did not itself make recommendations about, is the issue of facilities in the form of capital, especially in the form of funding for buildings. (I am not here referring to the specific needs for capital that result from the major restructuring of London institutions.) It would seem that some, if not all, of the major centres for excellence (which need not be large) find themselves up against severe constraints in their capacity to take on additional research activity, and this takes the particular form of lack of suitable space to accommodate the researchers and their associated other space needs. Several important issues need to be resolved in this connection. One is whether Treasury rules would permit the use of what I understand to be recurrent money for capital purposes; another is the question of the ownership of any such estate created in this way (especially when it is not a part of trust property), and another is the question of whether the conventions about investment appraisal procedures ought to be (or, indeed, could be) followed in the same way in such cases, supposing that the other two problems were resolved. It seems to me also to be unlikely that satisfactory answers to these issues are to be found simply by relying on the market: for example, by channelling recurrent support only to those institutions having spare capacity and therefore lower marginal costs of supplying research, if only because these institutions may be far from being the best places for the research to take place. Good research, and good cost-effective research, is not necessarily the cheapest research. So there is a problem which may be particularly acute for the sort of health services research that does not depend upon a specifically NHS base and which would be unsuitably located on trust property. I have in mind particularly research based in universities or in fundholding general practices. Whether the answer lies in developing some supplementary capital funding sources within the NHS for such support or for extending loan arrangements, or rental agreements, I cannot say. Again, this seems an issue pre-eminently suited to a preliminary discussion at the new Forum. The issue of marginal capital costs of research is not, of course, solely one that concerns the NHS's own R&D programme but also the programmes of the medical charities and the research councils.

Service Costs

One of the issues that led to the establishment of the Task Force was a perceived threat to clinical trials, especially multi-centre trials and trials in highly specialised units with difficulties in recruiting patients in sufficient numbers, and to major centres dependent on tertiary referrals, in the form of a reluctance in the new NHS of purchasers to buy services inflated by research costs and of trusts to accept service contracts making no allowance for research costs. We saw a necessary if not sufficient condition for resolving this issue to be to identify both the research and the service costs and to ensure that these were built appropriately into service and research contracts in ways that were acceptable to the institutions on whom the costs would fall and in a way that was seen as fair and acceptable to service purchasers and research sponsors. My understanding is that work has yet to be got under way on the accounting side to develop appropriate conventions for the costings and that, in the mean time, regional directors are being urged to smooth the passage of such research by reminding institutions that the R of SIFTR is intended partly for this purpose and, where necessary, by using regional funding, for example to support service costs in research into general practice. It is plain that a set of conventions needs to be developed to cover the various ways in which it might be appropriate to share the patient costs between service purchasers and research sponsors. I doubt whether a simple and standard formula will do the job. There is, after all, a major difference between a research project in which an entirely new procedure is being investigated, where the entire exercise might be considered to be "research", and one where there is a relatively minor additional cost in the form of extra patient investigations and only marginally longer spells of hospital inpatient stay. The application of any such future conventions is likely to be highly dependent on the brokering role of Regional Directors of R&D and the depth of their relationships and the mutual trust they have established in their local research communities and health care commissioners. At the end of the day, I suspect that this is an area where the subtle managerial skills of RDRDs will most be needed.

31 January 1995]

[Continued]

Moreover, in some areas of work, I suspect that a merely responsive role of R&D policy to the patterns of referrals that might emerge in the market for medical care will be inadequate. The research needs of some groups for patients may require a planned concentration of such referrals and active intervention to secure it.

Quality assessment and assurance

The main plank of quality assessment and assurance we saw as peer review. However, we recognised both that this is a highly costly exercise, especially in the time of researchers themselves, and that some of the “Cinderella” areas of research in community care might be very vulnerable to the early application of a fully rigorous system of peer review. In time, however, we expected that this field would be treated no differently from any other.

There are notable lacunae in the present scope of peer review which are less defensible. Our view was that *all* R&D which uses NHS resources (including patients) should be subject to peer review, including “implicit” research, that funded out of trust funds, that funded by the smaller charities, and that funded by industry. Moreover, we did not necessarily see the scope of peer review as being focused solely on *projects*. There is much to be said (though we did not say it!) for a focus, where appropriate, on *individuals*, whose track record or promise suggests that giving them a relatively free head would be a productive way of spending some of the NHS’s R&D funds (not to mention the research councils’).

Some alarm has been expressed at our proposals for an HEFCE or Thompson Review type of quality assessment, that included researchers not currently eligible for inclusion in the RAE, to back up the facilities support element of our proposed financial package. My own view is that, without the cooperation of the HEFCE, any such independent exercise would be far too costly. However, I am told that some preliminary discussions between the NHS Executive and the Funding Council give cause for hope. The simplest and least bureaucratically costly thing would certainly be for the HEFCE to agree to extend the range of its enquiry by the creation of appropriate new units of assessment, or the extension of existing ones, especially into applied topics, and to consult the R&D Directorate in the composition of the Panels. It seems intolerable to subject universities to an RAE in 1996, 1997 and 2000, so I do not expect anything much to be possible before the Research Assessment Exercise in the year 2000 and what we called “facilities” support will have, until the outcome of that exercise (assuming it to be extended as I have suggested), to make do with such external quality judgments as are available unless arrangements can be made for a minor exercise in 1997 that focused only on those research active staff not included in the 1996 exercise.

Cinderella subjects

The Task Force drew attention to the importance of R&D in community settings for health care and to developing research strengths in the main disciplines likely to be involved in doing the research. Some of our recommendations were directed to the opening up of the funding stream so that it could be more readily accessed for these purposes and to support service costs of such research. My own view is that we can hope for little in the way of any transformation of the culture of the NHS towards awareness of relevant research outcomes and the implementation of practice informed by them, without this, especially given the increasing role of GPs as purchasers. Culture change is needed not only for medical practitioners but also for the nursing profession and the other allied professions. You will not need reminding that the community is increasingly the setting for health care, nor that, of the 29 nursing units of assessment in the last RAE, there was no 5, only three 4’s and two 3’s, nor that, of the 34 units of assessment in Other Studies Allied to Medicine, there were only two 5’s, five 4’s and one 3. There is therefore urgent business to be done here. My own feeling is that we shall have to target a few of the best existing centres in order to develop both the necessary training and the community research partnerships. This might well be an early matter for the newly constituted Central R&D Committee to consider. We were told that there are technico-legal difficulties in offering facilities support to fundholders. At the very least I would hope to see some major support of programmatic sort for work in this field and a workable way of supporting any service costs of such research.

Contracts and bureaucracy

Whatever arrangements are adopted in future should minimise the costs of bureaucracy and management both for the NHS and the research community. While it seems inevitable that some of our proposals, such as the new costing arrangements for R&D having service cost implications, will create further costs on both sides, provided that they are kept at the minimum necessary, it was our judgment that they were worth it, especially if the alternative is to have good research never getting off the ground or withering once it had. One must not allow the perfect to become the enemy of the merely good—especially if the “perfect” is ultimately self-destructive.

It is important not to infer that the increased use of “contracts” for R&D necessarily implies rigidity or short-termism. The Task Force saw no reason why contracts should not be as flexible, and embody a good deal of individual discretion for researchers, as the circumstances and common sense demand. Moreover, we

31 January 1995]

[Continued

saw no reason why "contracts" should be perceived as inherently short term. They could (as indeed some have) been awarded for long periods of time, 10 years or more (the latter, for example, in cases where senior posts are being supported). Nor does a contract have to be made artificially specific. The advantage we saw in an intelligently interpreted system of contracting was its explicitness about what was going to be done (even in the case of making a research fishing expedition explicitly that), how success or failure would be judged, and what the work ought to cost. None of us in the research community ought to have the right to implicit public money awarded casually and for implicit purposes with no attempt to assess the value of that implicit activity.

Declaring implicit research in trusts

One of the most quantitatively problematic issues, which the Task Force did not attempt to resolve, was the size of support for research that service providers fund on their own account, partly out of special trustee accounts, partly with the agreement of purchasers out of patient care contracts, and partly only implicitly out of patient care contracts. We had no hard empirical evidence on the size of this latter component, which we called "implicit" research, but were advised that it was a very large sum. It includes R&D sessions in consultants' and other staff contracts. It also includes much work by clinical scientists in trusts. In the internal market for patient care, this funding is plainly at risk, for it seems extremely unlikely that it could all become embodied in explicit contracts for R&D made with any trust's purchasers, even if more did. It was said to us that such research is often an important preliminary to more substantive and explicit research, but much of it may also be substantive (though it must be said that a lot of it is not peer-reviewed, even when it entails higher patient care costs—in which case we argued that it should be subject to peer-review). It seemed to us important that these funds be protected for R&D and we proposed that they be progressively declared by trusts and added to the single funding stream. The word "progressive" needs underlining and made more clear than we made it in the Report.

In one sense, "progressive" means that we did not expect trusts to be able to identify and therefore declare all such implicit research with great accuracy and at a moment's notice. One approach would phase declaration over time, so the recurrent stream from this source would build up only in a progressive, that is to say, cumulative fashion. But, if trusts are to have any incentive at all to declare all the costs of implicit research, they must clearly be reassured that declaration will not be followed immediately by "confiscation"—which is how it might appear in a system that removed a sure current resource and substituted in its place the uncertain prospect of getting it (or more, or less) back via competition for a share of the consolidated stream of funds. It seems to be essential, therefore, that such funds as are declared be regarded as at the disposal of the trusts declaring them for a sufficient period of time for it to be worth their while declaring them. There is the risk of creating a classic prisoner's dilemma, in which trusts *collectively* might concede the long-term benefit of identifying and protecting this money, and indeed the Task Force's arguments in favour of allocating it more effectively, yet *individually* see such a disadvantage to doing so that they all end up in the worst of all possible worlds, in which increasing competition in the patient care market causes this element of R&D funding to shrivel up altogether. The risk with this, gradualist, sort of progression is that, despite incentives, many may still not declare, or not declare much, so the yield would be small and the overall resource eventually be seen to be too small.

An alternative, which I incline to, is to prepare early guidance and ask trusts to make the best estimates they can of their current annual spend on implicit research, allocating it as best they can to our three categories: project and programme direct and indirect costs, service support costs, and facilities or infrastructure. Such declared funding would still need protecting for a reasonable period for those declaring it, but this approach would have the advantage of getting this element immediately and roughly comprehensively into the new single funding stream pretty immediately. Subsequent periods would then be opportunities for further refinements and more accurate allocation across the three types of support rather than a progressive build-up of the total contribution of this element to the total funding stream.

Special treatment for London?

London undoubtedly contains some of our finest research institutions and largest concentrations of expertise along the spectrum and across many relevant branches of science, though it by no means has a monopoly on excellence. The greatest concentration of excellence is in London, however, and it has taken decades to build (and could be destroyed in months). One can make criticisms and see weaknesses. Most of the best health services research is not, in fact, done in London at all and there are many four and five rated clinical units of assessment outside London. Moreover, London is costly. That is true not only for service provision but also for teaching and research. Nonetheless, such excellence is worth preserving and it is my belief that the various forms of support for R&D which the Task Force proposed should be sufficient to ensure the future of the best institutions, departments and units that are there (as well as any that might develop), provided that R&D costs and expected outcomes can be explicitly evaluated, and provided that the allocation of facilities support gives due recognition to the demonstrable and, of course, demonstrated needs of nationally important centres. However, I suspect that neither the market for patient care nor the evolving

31 January 1995]

[Continued

market for R&D will be sufficient to produce sensible results if left to operate without some further controls and central direction. I think these issues arise particularly for those groups which depend on tertiary referrals and for other centres of specialist excellence. There will be arguments to be made on both sides for keeping some centres of expertise in the capital or for developing them further in other major research concentrations in the rest of the country. But what would be intolerable would be for any such responses to market pressures and individual initiatives to take place in inexorable dribs and drabs which debilitated extant teams of researchers and slowed down the ability of others to develop the necessary critical masses, with concomitant disastrous effects on morale. That way lies mediocrity and second-rateness and the destruction of some of our best institutional reputations.

There is a bullet to be bitten here for, if it is *really* believed anywhere that major concentrations of excellence of the sort found, for example, in the Hammersmith and UCL are placed in sites that are simply too costly, then the implied need for change will need to be discrete rather than marginal, and will need to be planned with great care so as to preserve teams, networks, extant programmes, and individuals' careers and supported with appropriate capital funding. Any such change would, of course, be hugely costly and disruptive. If that is *not* believed to be the case, then it may be that a different bullet needs to be bitten, which is to devise a quasi-permanent system of supplementary support from the collaborating partners which enables the research activity to continue where it is so long as the quality assessments warrant it. I cannot see the case for general institutional subsidies whose ultimate destination and effects are untraceable and for which there is no accountability at all. Properly handled, facilities support is there to meet this need, and could do so in a more sensitive and carefully targeted fashion than the R of SIFTR or the current temporary arrangements for the London postgraduate teaching institutions. After all, cost-effectiveness in R&D is justified by the same ends as cost-effectiveness in inpatient care—the more efficiently R&D resources are husbanded, the more R&D work they can do—the more the outcome from our limited R&D resources. And, as I said earlier, research that is merely cheap is not necessarily good nor cost-effective. There is no reason why facilities support, or indeed either of the other two forms of support, should not recognise that some centres are inherently costlier than others.

Getting purchasers on side

I have been told that the Task Force's strategy of developing the single funding stream as a levy on purchasers (including fundholding GPs) is highly risky, given their extremely uneven commitments to (and experience of) R&D, of which there was much evidence from our consultation. I have to agree with the riskiness of it, but take the view that the risk is there anyway. It would only be window-dressing to fund R&D support by, say, top-slicing the budget centrally. Purchasers collectively and individually will be perfectly well aware that R&D funding comes at the opportunity cost of current health care purchases, whatever the mechanisms (as, indeed, current health care is purchased at the opportunity cost of R&D). We were extremely anxious to increase the voice of purchasers in the priority setting process, both centrally and at regional levels, so as to ensure that the priorities of the NHS R&D programme reflect the needs of the NHS, partly because their collaboration is essential (for example in ensuring that suitable patients in suitable numbers are available for research of various kinds and with the funding support of many different funders) and partly because their involvement must be a part of the total strategy for promoting evidence-based health care (which should be more than just an information strategy). The levy symbolises the seriousness with which the voice of purchasers is to be taken and is also a signal to central R&D managers and to the research community in general that the task of creating a widespread research-oriented culture in the NHS has to command a very high priority. If we fail in this task over the next few years, the consequences could be very grave for the future of R&D in the NHS and would have been grave whatever the precise form in which the funding stream was presented. We hope to have given it a very sharp focus and to have concentrated minds. You will all have key roles in this endeavour, which will probably need systematic orchestration by the new CRDC and Professor Peckham's R&D Directorate.

Envoi

Let me say finally that it has been extremely gratifying that the work of the Task Force seems in general to have received so uncompromising a welcome and that it should command the interest and commitment of the Secretary of State herself. We are plainly into serious business. The stakes are high but I think the future auguries are good. I am much impressed with the strong support for the research community that emanates from Professor Peckham's division and with its strong commitment to networking and consultation. The Task Force was concerned to ensure that the transition be as smooth as possible and I detect a commitment to this too. However, its successful implementation will also require the support and collaboration of the research community.

Much of the environment in which we operate today is not particularly friendly to the research community and it needs convincing both that there is a pay-off to R&D and that we have our research houses in good order. The Task Force's framework should enable us to offer these assurances but, in the end, it is down to the research community to provide the proof of the pudding and to supply Professor Peckham with

31 January 1995]

[Continued]

plausible—and empirical—arguments. Mere assertion will not do. It will be especially important for us to convince purchasers too, and to enlist their support and commitment in a world where the levy will be seen as directly competitive to current health care funding.

I hope you will not bring to this a frame of mind that hearkens back to some past, and probably mythical, halcyon era. There is no point in wishing the problems away or regretting the history that makes the proposed changes necessary. There is no point in comparing today with things a decade or two ago. But there is every point in comparing what you imagine the research world would have been like in five years time had we merely gone on as we are with what it can be like post-Task Force. My own opinion is that disaster lay ahead, and not only because of the effects of the internal market for patient care on research but also because there was so much that was opaque, creaking, unfair and inappropriate in the accretion of history. I am by nature an optimist who tries to ensure that his own institution sees every potential threat as a real opportunity. But for us all to realise these opportunities in the sort of world envisaged by my Task Force colleagues and me requires us all to put our shoulders to the wheel to promote a dramatic culture change, to get the national framework right, and to ensure that our own institutions are poised to take full advantage of it. I wish you all the very best in these tasks and urge you to lend Professors Peckham and Smith all the support you can muster during the implementation of our recommendations.

Memorandum by Professor Maggie Pearson

Thank you for your invitation to give written evidence to the Select Committee's enquiry into medical research and the NHS reforms. I am delighted to have the opportunity to do so. My evidence is submitted on the basis of my experience as (i) Professor of Health and Community Care in the Faculty of Medicine at the University of Liverpool and Director of the North West RHA Health and Community Care Research Unit. The Chair and the Research Unit were both established by the former Mersey RHA, through its Regional Director of Research and Development, and therefore as a direct result of the NHS R&D Strategy; (ii) a member of the NHS R&D Task Force, chaired by Professor Culyer; and (iii) a member of the RHA's Small Grants Research and Training Committee. In December 1994 I was appointed a member of the Central Research and Development Committee of the NHS.

My observations are organised according to the three part questions set out in the Call for Evidence.

(i) THE NHS R&D STRATEGY

- (a) *a great deal has been achieved* in fostering an "evaluative culture" within the NHS in the four years since Professor Peckham's appointment as DRD, to the great credit of Professor Peckham and those who have worked with him in the Department of Health's Research and Development Division, and in the Regions.

The genuine interest which has been generated in sound R&D is evident in the large number of applications for national and regional competitive research funds; in the increasing number of approaches to Research Units such as mine to undertake research for local purchasers and providers; and in requests for places on research training courses, and individual approaches for research guidance and supervision, from NHS staff with little or no previous research experience. Several NHS Trusts have established specific R&D posts, including full-time R&D posts in nursing, in addition to the appointment of honorary or part-time Trust Directors of R&D, who are generally from the medical profession.

There is, therefore, a ground swell of enthusiasm for *research* within the NHS, which is to be greatly welcomed and sustained. There are, however, potential and actual frustrations, and the origins and motivations of that interest are not always clear. In some cases, the interest in research may reflect a person's perception of what will help their personal career prospects more than a genuine interest in generating knowledge by robust methods which can underpin appropriate service developments. I return to this point below.

- (b) despite recent welcome developments, *there remains a lack of sufficiently established research capability in some health professions* (eg, professions allied to medicine) *and in some disciplines crucial to health services research* (notably health economics and statistics, in both of which there is a national dearth of expertise). All health professions would benefit from training in these disciplines. In those professions (medicine, nursing) *where research is established, the capability is insufficiently widespread* and, in the case of medicine, often restricted to biomedical research paradigms.

As a matter of urgency, we need to develop, actively, biomedical and health services research capabilities across the professions. Taught courses are necessary but insufficient. There is no substitute for well guided practical research experience. The MRC/RHA Fellowship Training Schemes are a welcome development, and they need to be awarded to people from a *range of professions*, not just medicine. The Department of Health has research training schemes for nursing and the other professions allied to medicine, but they are fiercely competitive and there are too few. Some are restricted to PhD studentships, rather than encouraging more advanced development.

31 January 1995]

[Continued]

There is a notable exception: the DH Postdoctoral Nursing Fellowship scheme, in which one award is made each year, and has resulted in some nurses becoming involved in health services research with a wider perspective than their previous research.

- (c) *we need to develop further the research commissioning capability*, particularly if local health purchasers and providers are to continue to encourage and commission research of direct local relevance. This requires an understanding of the resources (including time) required to design and conduct a piece of good research, including seeking ethics committee approval, and of the potential and limitations of different methods. I return to the question of Local Research Ethics Committees in (iii) below. Those commissioning research need particularly to be aware of the importance of reviews of previously published work, to avoid re-inventing any wheels.

There is a clear role for Regional Offices in developing this commissioning capability, which must be widely advertised as available and supportive to local enthusiasts, and certainly not deterringly censorious. The R&D Directorate in North West Region has taken a positive approach to requests for support in developing and commissioning R&D, working with those who are new to research, to encourage and support them.

It is particularly important that senior managers, anxious to apply R&D to service problems, understand the scale of resources implied. My Research Unit is often approached by local health care purchasers and providers and social services departments which wish to commission a small piece of research, to be conducted immediately. In the current climate, the resources for such commissions, however small, have often been hard-won amidst competing claims.

This enthusiasm, which is not only restricted to local organisations, can result in disappointment for two reasons: first, established Research Units may not have staff of the requisite experience immediately available to undertake the research. Second, there can be utter disappointment, or open disagreement, when the rigorous research does not generate the results expected by the commissioner. This underlines the importance of research commissioners understanding what research *can* achieve.

- (d) *other NHS policies and circumstances may limit the scope for R&D*. There are several potential tensions:

- (1) *between the R&D strategy and training policies*. Junior medical staff often move on, within rotations, before a sound project can be completed, and they may be more concerned to publish something quickly, to have papers on their cvs for the next post, than to tackle a significant project which would be an R&D priority. The implications for R&D of the introduction of the junior doctors' six hours' weekly protected education time will need to be addressed.

As research becomes more significant in other health professions, similar tensions may develop. To gain promotion, some nurses now feel the pressure to publish, and look for 'snappy' projects which will lead quickly to publication. Long term research may therefore be accorded a lower priority.

The crucial relationship between the R&D strategy and training was not within the remit of the Culyer Task Force, but was identified in our discussions, and needs to be properly addressed.

- (2) *there may be commercial sensitivities which prevent the collection of research data*. When purchasers commission research, provider units with whom they hold contracts may be reluctant to reveal information to the researchers, and there may be commercial sensitivities, particularly about prices and performance if more than one provider unit is involved;
- (3) *as the intensity of clinical workload increases, staff working in direct patient care may feel that they can not make the time for research, and they may be reluctant to evaluate their practice*. It is threatening to discover that one's practice has been more ritual than rational, and it takes confidence and humility to change. Staff under stress are likely to feel unable to subject themselves to such a potential threat, and may resent the resource being overtly invested in new R&D.
- (4) *it is crucial that R&D is linked with audit* at the appropriate time, so that standards set are knowledge-based. With separate budget streams and directors, there is the potential for the divergence of the two.

(ii) *The Culyer Report*

As a member of the Task Force chaired by Professor Culyer, I was pleased that our report and recommendations made visible the key issues of enabling and financially supporting high quality clinical and health services research in primary and community care settings, and the need to develop the research capability across the range of health professions which will be taking an increasingly prominent role in the development of health care to meet the needs of the population in the next century.

31 January 1995]

[Continued]

- (a) whilst I welcome the consensus that R&D monies should be visibly accounted for, and accountable, *it is crucial that our recommendations do not quash the spirit of enquiry and curiosity which Professor Peckham has so successfully fostered across the range of health professions.* Enthusiastic, but inexperienced, researchers in the health professions including medicine may be particularly vulnerable if the baby of enthusiasm for research is thrown out with the bath water of previously opaque and unaccountable funding;
- (b) *the HEFCE and R&D quality assessment criteria must be complementary*, rather than in conflict, and *where possible* a single assessment exercise should be undertaken, to reduce bureaucracy and costs. My principal concern here is that HEFCE does not “value” review articles or dissemination in other than peer reviewed scientific journals. Publication in scientific journals may not result in a change in professional practice. *This whole question of quality assessment needs very careful thought and should reflect the purpose of NHS R&D;*
- (c) *the development of clinical and health services research in primary and community care settings needs to be actively encouraged* (including earmarked finance), as the balance of care shifts away from hospitals and chronic disease becomes more significant. There will be considerable liaison costs to working across a large number of small sites. The decline in referrals to specialist hospitals, rendering sample sizes too small for clinical trials, may be inconvenient for researchers. but *where* the changes in referral patterns reflect the development of high quality specialist care in district hospitals or in primary care, this is a welcome development to which research design should respond, giving local populations access to higher quality health care. The financial and emotional costs to patients of referrals and admissions to hospitals in other cities can be very high.
- (d) *the need to develop a high quality research workforce across the range of health professions*, which I have discussed at length above, was encoded within Recommendation 23 about a human resource strategy.

(iii) *Other challenges and opportunities*

Besides the impact of NHS resource constraints and training strategies on the potential for successful implementation of the R&D strategy, I have a particular and quite acute concern about Local Research Ethics Committees, and their key role in enabling local research to take place. There are several issues, some of which are fundamental to the ethical conduct of research, and some of which are more operational.

- (a) *there is a fundamental tension between an NHS patient's rights to autonomy and confidentiality and researchers' desire or need for access to clinical notes and/or personal details.* Within the research community, we perhaps have not really addressed this issue and its implicit tensions adequately (if at all). The Patient's Charter affirms the public's right “... to have access to your health records, and to know that those working for the NHS are under a legal duty to keep their contents confidential”.

Science and individuals' autonomy and privacy could be in conflict, and we need to find a positive way forward which respects patients' rights but facilitates sound scientific research which is in the public interest.

Hitherto, Local Research Ethics Committees have reviewed proposals and often given consent to researchers to have access to personal information and clinical notes, without requiring them to secure the prior consent of the patient. According to the Department of Health's *Draft Guidance on the Confidentiality, Use and Disclosure of Personal Health Information* (1994), health information may be disclosed without the patient's prior consent, *when such disclosure is in the public interest.* Bona fide and approved clinical and scientific research and surveys are included in the public interest justifications, and it is on this basis that many research protocols are designed, which involve reviewing notes retrospectively or prospectively.

However, during the past year, one LREC with which I am dealing has changed its practice and is no longer prepared to give such consent, clearly feeling that the public interest of scientific research does not outweigh the patient's rights to confidentiality. In correspondence, the Ethics Committee has affirmed that it sees its role as “very particularly siding with the rights of the individual”, and in its view “there are very limited circumstances in which studies may be undertaken without prior permission from the subjects concerned”.

The specific project in question is funded by the Department of Health, and aims to generate scientifically robust knowledge to inform service developments which can improve the detection and management of urinary incontinence, so that avoidable distress can be averted. The research was funded as part of a programme of research on disabilities, among which incontinence is acknowledged to be of significant prevalence. Before funding the proposal, the Department of Health sought the views of two scientific referees on our full scientific proposal. The study was designed to be conducted in three health districts, to maximise its potential generalisability. After

31 January 1995]

[Continued

six months' negotiations, the study has not been approved by one district, whilst it went ahead with immediate approval in two others.

Our methods involve us knowing the names and addresses of people using specific health services (out-patient clinics, district nursing services, in-patient services) so that they can be given a questionnaire which they have the expressed right not to complete, without jeopardy to their future care. On scientific grounds, we wished to compare the age and sex of responders and non-responders to the questionnaire. The LREC felt that we should only know the volunteered identity of those who responded.

We wished to have an "opt-out" clause so that responders to the first questionnaire would indicate if they did not wish to be contacted again for a follow-up interview, but the LREC required us to have an "opt-in" clause, at which point those respondents returning the questionnaire could, if they so wished, reveal their identity. The technical problem with this suggestion is that we know that response rates will be lower, because of the extra effort required of the potential respondent, and results will therefore be less generalisable. This may, however, be the justified scientific price of properly protecting patients' rights.

We had also initially wished to be able to look at clinical notes to compare recorded prevalence of urinary incontinence problems with respondents' own accounts. On the basis of a small feasibility study in the two districts where we were given Ethics Committee approval to have access to clinical notes, we actually discontinued this proposed method of data collection. We judged that the quality and consistency of clinical data collected in different records was not adequate or sufficiently accessible.

It can be argued that patients *have not* given consent for their notes to be scrutinised by researchers, and therefore we should not jeopardise their autonomy and confidentiality by assuming consent. If scientific studies using routinely collected clinical data (sometimes retrospectively) are no longer deemed to be sufficiently in the public interest to warrant disclosure of personal information, even just name and address, *without the prior explicit consent of the patient*, then we need to find a way of informing patients properly beforehand, and acquiring their consent. Perhaps the way in which we consent by default, but can refuse, to see medical students is a possible method.

I have gone into some detail about the nature of the negotiations in which we have been involved, because this is complex territory, which I know other researchers are also, now, confronting. There are fundamental questions which need to be tackled, if scientific research, with adequate definition of sample bias, is to be possible and is to be conducted ethically.

- (b) *there is a need for consistency and reciprocity between Local Research Ethics Committees in remit and operation.* I am currently dealing with seven LRECs, each of which has different written and unwritten rules and norms. I have indicated above that in a multi-centre study involving three districts, we have approval withheld by one, after protracted negotiations, whereas approval was given immediately by the two others.

The costs are substantial in time and effort of liaising with several committees, particularly when each has different policies regarding Chair's action on the content of questionnaires, or the need for each version of every proposed data collection document to be seen by the whole Committee. Where such negotiations are protracted in respect of externally funded research projects, the costs in researchers' salaries whilst approval given is significant;

- (c) *as the nature of research conducted within the NHS changes, to include more health services research, it is crucial that Local Research Ethics Committees are adequately advised on technical matters,* whether by including representatives of relevant disciplines in their membership, or by seeking professional advice. I have known instances of such advice being sought in respect of unstructured interviews, but then dismissed out of hand. Some of these issues relate to Ethics Committees' understanding of, and respect for social science research methods and researchers. We need to find a positive way forward, as multi-disciplinary health services research, which addresses patients' views and experiences, develops.

If the Select Committee requires any further information on any of these points, please do not hesitate to ask.

24 January 1995

31 January 1995]

[Continued

Letter from Professor R D H Boyd

Thank you for your invitation to submit evidence to Sub Committee I. As a Member of the Culyer Working Party I fully endorse its recommendations but am grateful for the opportunity to comment on its implementation and related issues.

I have three areas of concern:

1. RESEARCH IN PRIMARY AND COMMUNITY CARE AND NURSING AND OTHER HEALTH PROFESSIONS

The momentum already achieved by the NHS R&D Strategy in this area needs to be endorsed and extended in the areas of primary and community (including social) care, general practice, nursing and other professions allied to medicine widely interpreted. Progress has already shown promise but if it is to mature and develop further four constraints need addressing:

- (a) Shortage of personnel. This is particularly true of health economics and of aspects of social sciences applied to medicine but extends much more widely to the shortage of international level research expertise in many non medical clinical subjects reflected in the last HEFC research selectivity exercise. Positive programmes of recruitment and reorientation are required.
- (b) The potential conflict between the "medical model" and other approaches to health care research.
Arguably, our Universities have been less effective than, for example, US ones in organising effective interdisciplinary team work between Bioscientists and Clinicians; we need to avoid the same mistakes being repeated between clinicians and other disciplines in Health Care Research.
Sensitive management and effective organisational systems nationally and locally need to be further developed to encourage effective multidisciplinary working and to reduce subject based prejudices and protectionism.
- (c) The inappropriate concept that Clinical and Biomedical research is predominantly long term, and blue skies and that Health Service research by other disciplines is short term and applied. In actuality, much social, epidemiological and economic research is long term and much clinical science is problem driven and short term.
- (d) Funding.

Despite these caveats there are many signs of exciting new developments in this area since the strategy was established and further funding will be required to maintain and enhance them.

2. BALANCE OF STRATEGY

Until Culyer, the NHS R&D Strategy was essentially one complementary to existing clinical research. The word is, for example, used by the Director in his Foreword to R&D Priorities in Cancer, "it is intended that the programme of work commissioned as a result of this review will complement the work of others in the Cancer Research field."

It is clearly essential that this complementarity continues but it needs to be clearly stated and widely understood that an inevitable consequence of the post Culyer single funding stream is that the boundary or boundaries across which complementarity must be made to work will shift sharply to include large areas of biomedicine and clinical science. This follows from the very substantial existing NHS spend in these areas under the SIFTR and SHA Heads. Without such rebalancing of the strategy, there is serious risk of damage to strong elements of the National Clinical Science Base, an issue of importance not only to the NHS but also more widely as pointed out by Sir Richard Sykes, in a recent letter (*not printed*) and in the draft report of the Health and Life Sciences Panel to the Technology Foresight Steering Group.

The point could be helpfully addressed if "Research and development in the New NHS—Functions and Responsibilities" was reworded, perhaps as indicated in the appended note.

I have no quarrel with the need for available funds to be allocated transparently and accountably and to be peer reviewed so that they can be focused on individuals (a particularly desirable element), groups and institutions working on areas of potential or actual importance long or short term in a high quality way. This will lead to losers and winners. However, specific instances in which Annex A has been applied at the existing boundary to favour new areas of research, currently of speculative quality, at the expense of well reviewed, high quality, relevant long term research gives me concern, unless the strategy is seen to have been rebalanced following Culyer.

31 January 1995]

[Continued

3. FUNDING

It follows from the comments in paragraph one that further funding is required in this area and from paragraph two that while funding should be more sharply focused following peer review, it would be unwise to run down the overall volume of clinical and biomedical research. Increased overall funding will be required if the great opportunities opened by the NHS R&D Strategy and the Culyer Report are to be realised.

This point needs to be made with particular force because, as existing research, much of good quality, funded by inexplicit streams becomes explicitly funded, that very explicitness will render it vulnerable. Research and innovation throughout the service which have contributed so powerfully to quality throughout the NHS over the last decades would then be at risk, as well as the newer developments.

Thank you for the opportunity to comment.

23 January 1995

Annex A

NHS R&D STRATEGY—AIM, GOALS AND OBJECTIVES

Proposed amendments: delete words in [], add words in italic

The AIM of the NHS R&D strategy is to secure a knowledge based health service in which clinical, managerial and policy decisions are based on sound and pertinent [information about] research findings and scientific developments. This provides the basis for maximising the effectiveness, efficiency and appropriateness of patient services.

The strategy has the following GOALS and OBJECTIVES:

KNOWLEDGE:

To substantially increase the knowledge base required to evolve and apply effective, efficient and appropriate services. This includes *support for research*, knowledge arising from research and knowledge about scientific and technological advances.

- (i) To work with NHS staff to identify and prioritise the R&D requirements of the service
- (ii) To ensure that priority needs for R&D are met by the NHS and other research funding bodies and through international collaboration
- (iii) To ensure that NHS expenditure on R&D is well managed and targeted for maximum benefit
- (iv) To work with others to ensure an adequate supply of skilled staff to undertake the R&D needed by the NHS
- (v) To scan the external environment in order to generate knowledge about scientific and technological developments relevant to the NHS.

INFORMATION:

To ensure that information about existing research and science based knowledge is available and accessible for decision making and that information about unmet needs for knowledge shapes the R&D agenda.

- (vi) To ensure that knowledge from research and the science base is available to NHS decision makers (policy makers, managers, clinicians and patients) in a way that is appropriate to their needs
- (vii) To ensure that information about research requirements and about ongoing and completed research is available to those planning and managing R&D.

IMPLEMENTATION:

To promote the use of research and science based information by decision makers in the NHS.

- (viii) To work with decision makers in the NHS Executive and the field, and those supporting them, to help them use information about research based knowledge
- (ix) To develop ways of holding decision makers to account for their use of information about research based knowledge.

31 January 1995]

[Continued

CULTURE:

To instil into the NHS a culture of evaluation, review and learning, so that information about knowledge is actively sought and applied intelligently in decision-making.

- (x) To develop R&D as a part of the regular activity of policy evaluation
- (xi) To work with others to ensure that managers, clinicians, policy formers and service users appreciate how research can facilitate their decisions
- (xii) To develop alliances between the NHS and the research community.

Second memorandum from Professor Robert Boyd

"Specific instances in which the [objectives of the NHS R&D Strategy] have been applied . . . to favour new areas of research currently of speculative quality at the expense of well reviewed high quality relevant long term research".

Examples personally known to me relate to the Regional Research Infrastructure Programme of the previous North Western Regional Health Authority predominantly but not exclusively operational in the teaching hospitals associated with the University of Manchester Medical School. It has now been discontinued. I here refer as a specific example to its former work in the Central Manchester Trust.

The Central Manchester Healthcare Trust is one of six Trusts receiving Band I SIFTR with which that Medical School is associated. In it there are 17 ongoing research areas active at the start of 1994-95 supported at a total cost of £0.49 million by the above programme. In that Trust all these have been evaluated by peer review. The subject range is wide and included amongst them are:

1. Statistician in Psychiatry (Professor Francis Creed). The post performed an important infrastructure function in a department which was returned in a unit of assessment rated five in the last HEFCE Research Selectivity Exercise and which is in receipt of MRC project funding; it has a major focus in social psychiatry;
2. Technician in Bone Disease (Dr B Mawer and Dr M Davies). This group is in receipt of an MRC programme grant and was in a unit of assessment returned as grade 4 in the last HEFCE exercise;
3. Placental Transport in Abnormal Pregnancy (Dr C Sibley). A group in receipt of a five year special project grant from the MRC in a unit of assessment rated four in the last HEFCE exercise.

These examples and others have been recognised as being worthy of unconditional support following peer review by the Research and Development Committee of the Trust in question but funding was withdrawn following a decision to cease Regional Infrastructure funding by the then North Western RHA to release resources for Health Services Research.

NHS infrastructure support for clinical research such as this is also not a prominent feature of the new combined North West RHAs R&D plan (19 October 1994). This emphasises Health Services Research, supporting *inter alia* locally relevant programmes to be carried out by the National Primary Care R&D Centre, which I chair. It also includes other such highly desirable developments as (para 8.2) technical support for R&D, and (para 8.3.1) audit and basic training in Health Services R&D.

However, if clinical science and clinical research of high quality are to be adequately protected once SIFTR and SHA funding become part of the single funding stream, they also need to be fostered by the NHS R&D strategy. Infrastructure funding within NHS Trusts will be essential. The National and Regional strategies therefore require adjustment to ensure this is achieved.

30 January 1995

31 January 1995]

[Continued

Examination of witnesses

PROFESSOR TONY CULYER, Professor of Economics and Pro-Vice-Chancellor, University of York, and Chairman of the NHS R&D Task Force, PROFESSOR MAGGIE PEARSON, Professor of Health and Community Care, University of Liverpool and Director, North West Regional Health Authority Health and Community Care Research Unit, PROFESSOR INGRID V ALLEN, Professor of Neuropathology, Queen's University of Belfast, PROFESSOR ROBERT BOYD, Professor of Paediatrics and until recently Dean of Faculty of Medicine, University of Manchester, Chairman of Manchester Health Authority and of the National Primary Care Research and Development centre and MR JOHN H JAMES, Chief Executive, Kensington & Chelsea & Westminster Commissioning Agency and member of the NHS Standing Group on Health Technology, were called in and examined.

Chairman

500. Professor Culyer, thank you very much for coming to see us this afternoon. I would ask simply whether at the outset there is anything you would like to add to the written evidence you have produced, or shall we go straight into the questions?

(*Professor Culyer*) My Lord Chairman, thank you very much for inviting us, it is a genuine pleasure to be here and I think we are looking to you as allies, I hope, in developing the work that the Task Force has set in train. Perhaps it would be worth my while just prefacing what is to come by saying, as you will I am sure be aware, that the Task Force really focused on principles, structure and creating what we hoped would be an enabling framework. We agreed on that structure, we agreed unanimously on the Report itself but there are of course many questions of detail which we did not thrash out together and therefore on which we may not agree. On such matters I hope you will not necessarily expect us today to speak with one voice. Indeed I hope very much this session might be a session in which all sorts of ideas, even if imperfectly formed, might be thrown into the pool and form useful grist for the mill. Aside from that, I would be happy on behalf of my colleagues to say, let us go into your Lordships' questions.

501. What do you make of the reactions so far to your report?

(*Professor Culyer*) There was a worrying delay initially, for political reasons we all perfectly well understand. Subsequently I think the response has been quite gratifying, both from the Department of Health and from the Secretary of State herself, and from the R&D community broadly interpreted. It seems the research community as well as the research sponsoring community have welcomed the report as providing at least a useful framework for taking matters forward, and my impression is that people are taking the issues seriously and responsibly and engaging with them quite imaginatively. I had an excellent discussion at the 1942 Club with senior members of the medical profession which I thought was in many ways just the way I hoped it would work; they were engaging very productively with it I thought.

Lord Nathan

502. Professor Culyer, I was much struck by the comment in paragraph 4.12 of your report relating to primary and community care and the related paragraphs both in that section and in section 3, and the first question was what your view was as to how this had developed since your report had been published? There is a related question which arises

from Professor Pearson's evidence, on page 4 at paragraph (ii)(c), headed "The development of clinical and health services research in primary and community care settings", and I wondered if you had any further comments to make on what I found to be an extremely interesting paragraph?

(*Professor Pearson*) Thank you very much. I am glad you found it interesting, I am very fortunate in that health services research with a focus on primary and Community care is a very interesting career for me. I think there are two sets of issues really. One is that as the balance of care shifts from hospitals to community settings, just as people talk about the money following the patient, clearly the R&D also ought to follow the patient, in short. It is not an easy issue for several reasons but, as I have set out in my evidence, there has been a shift in the balance of care, indeed some research I am currently engaged in is demonstrating that some people are being discharged and re-admitted five, six times a year, and in that situation where the care is clearly shared across the primary community care settings one of the questions is where should the research driver be. So there is a big question of liaison across sites within community settings and between primary and secondary care. One of the problems with that is that the research liaison costs, if you like, are quite phenomenal. Several projects which I have in the community setting involve liaison with departmental nurse managers, different general practitioners and so on, and it is not as easy as doing it in one hospital where the lines of command may be more straightforward—they are not always, but they may be. I know many colleagues have concerns about the impact of that shifting care on the ability to undertake high quality clinical trials, and there is a real tension between the interests in terms of the cost to the patient of being referred to big centres, and their interests in being treated near to their homes. I think that is an issue we need to grapple with and there are no easy answers. The second set of issues is really around the research capability in primary and community care settings and in new disciplines which are seen to be more appropriate in those settings. I have to say that it is largely true, though not explicitly the case, that research has been less well developed in general medical practice and general dental practice than in hospitals, though there are some notable exceptions which we should applaud. It is also the same in nursing, that nursing research has tended to be developed more in hospital settings than community settings, but again there are areas in hospitals where nursing research could be developed. The other professions allied to medicine, such as the therapy professions, who themselves acknowledge the need to develop research capabilities, and who

31 January 1995]

PROFESSOR TONY CULYER, PROFESSOR MAGGIE PEARSON,
PROFESSOR INGRID V ALLEN, PROFESSOR ROBERT BOYD
AND MR JOHN H JAMES

[Continued]

[Lord Nathan *contd.*]

have responded to the Task Force on developing nursing research, say they themselves need to take on the issues. They are new professions in terms of being new graduate professions, they have not got a great tradition of university education, but they are coming up very fast. However they do not have a tradition of research education, so there are particular issues in different professions and they are complex.

503. I found that most interesting, but has anything happened in this context? I recognise the problems, but has anybody produced any solution since your report?

(*Professor Pearson*) What I know to have happened is that the Department of Health and the regional offices are taking issues of the workforce capability very seriously and are beginning to review what the needs are, so there has been some positive action in trying to better define the problem.

(*Professor Culyer*) The Department of Health is actually conducting an empirical review and quite an extensive consultation exercise with researchers in these, as I call them, "Cinderella" disciplines and also on these "Cinderella" topics. I do not quite know when they are due to report but that work was set in train immediately after the Task Force reported and which is now I believe well advanced. I have been in my own capacity as an academic visited by members of the team and interviewed quite searchingly on the problems of researchers and what we called research capacity. In preparation for the meeting I did select—I must admit not randomly—some quotes from the evidence we received. They are not terribly lengthy and I wonder if it would be helpful if I were to share them with you, or alternatively I could give them in writing?

Chairman

504. I think it would be helpful if you could hand them in afterwards. I had actually noted that particular paragraph in Professor Pearson's report because she herself has indicated that there are likely to be tensions developing between the needs of primary and community care on the one hand and research in that area, and the problems which are now being faced increasingly we understand in hospitals and especially in special units on the other. Evidence has been put to us, that tertiary referrals have been one of the early casualties of the NHS reforms and a number of bodies have brought to our attention clear statistical evidence to suggest that centres which have been involved in very high quality clinical trials, both for rare diseases and for common diseases, are now finding that those referrals are drying up and that there is a serious problem in that regard. We wonder what your feelings are because the MRC also said that your report did not make any proposal for protecting tertiary referrals which are crucial for many research teams in establishing an adequate patient base.

(*Professor Culyer*) In retrospect, my Lord, I regret that we did not give more time to addressing the issue of tertiary referrals as it perhaps has given the impression we saw no problem there. In fact that was not our view and I think the question of tertiary

referrals is very important, but it is also very complex and it seems to me that it is a matter to be given the highest priority by the new CRDC. I do not think it is true to say that the recommendations of the Task Force bypassed, as it were, the tertiary referrals. The costing arrangements that we proposed for referrals in general apply, of course, to all types of referral, including tertiary referrals. Once the impediment, as we saw it, on the cost side was removed it would be something that would work to ease the problem of recruiting people through ECRs as well as through tertiary referrals. I think there are other issues as well to do with, for example, a more planned approach to the location of major centres of tertiary referral which are also at risk in the internal market and which I think again need addressing directly. I certainly do not take the view that one can simply leave it to the market, that is to say the internal market for health care. Whether the answer is to give someone an explicit on-going responsibility for ensuring appropriate flows, by type and size and destination, of the sort that Professor Holgate has been given in the case of ECRs in his capacity as NHS Director of trials, I cannot say. I think there are major policy issues that need solving in a one-off fashion and then an on-going commitment to make sure that the policy is implemented and adjusted appropriately. There is a lot of detail involved here which involves asking research centres what their critical masses are, what the surrounding research and teaching synergies are. All those matters were far too detailed, of course, for us to address in the Report itself. As I said, it is certainly a question that the new CRDC ought to take up or perhaps a working party of it. It may be that John James would like to say something on this.

(*Mr James*) I think it does rather depend on what you mean by a tertiary referral. There is guidance which was issued in February 1993 which gives health authorities no choice but to pay for a tertiary referral, i.e. a tertiary referral in the sense of from one consultant to another consultant for the purpose of a genuine tertiary service or advice. We have to pay for that and for all of us there has been an increase in the total cost of the extra contractual referrals and this is a part though by no means the whole explanation of that. Where I think a problem has occurred is in centres which are not truly receiving tertiary referrals, attracting a sufficient volume of secondary referrals for their research purposes, and clearly those purchasers who traditionally supplied those larger numbers from further afield may feel under an obligation to redirect them more locally and there may be a financial attraction for them in doing that. I think that is the area. It is not truly the tertiary referrals field which the market may endanger, it is the traditional long distance flows of cases which can perhaps be treated adequately in a local general hospital but which perhaps ought to be treated, if you take the research interest as foremost, in a specialist centre.

505. It is that last point really. Perhaps I can give you two examples of the many that have been put to us: for instance, one of the first about which we learnt was the case of a rare condition called the Guillain-Barré syndrome where there has been a centre in

PROFESSOR TONY CULYER, PROFESSOR MAGGIE PEARSON,
PROFESSOR INGRID V ALLEN, PROFESSOR ROBERT BOYD
AND MR JOHN H JAMES

31 January 1995]

[Continued

[Chairman *contd.*]

Guy's Hospital that has been involved in multi-centre trials on an international basis and which had a steady level of referral from specialist neurologists in other parts of the south-east of about 20 patients a year to be involved in these international collaborative trials. Within the last two years the referral has dropped in 1993 to 12 patients and last year to four. Also, only today I have had evidence of a very specialised soft tissue cancer centre with expert pathologists, very experienced in this field, who have had referred to them considerable numbers of samples from across the country for specialist analysis by their very well-trained staff. The numbers of these were increasing by about ten or 20 per cent a year, but in the last two years in the internal market the pathologists in the small district hospitals are no longer referring them because of cost. That is the kind of problem that we are concerned about and we wondered what your views were about it?

(*Mr James*) As far as I am concerned, the health authorities whose patients were being referred into Guy's would have had no choice but to pay for the cost of those referrals because they were tertiary. The question has to be, therefore, who were the decision takers who were not making the referrals? My own experience has been, when I still had direct management responsibility for hospitals, that it might well be that it was the clinicians in local hospitals who were electing now that they had the control of the resources not to make the referrals and I have very specific examples of that in relation to Northwick Park and cases there.

506. We were told it was the managers who were refusing to pay. (*Professor Allen*) My Lord Chairman, first of all I would agree with all who have spoken already that this is an area where very much further study is necessary. I think from the point of view of research it is not necessary to take off the tertiary referrals as other kinds of referral. The key issue is critical mass for researchers as you have pointed out. I would say that there is some evidence which has been accrued and that comes from the Medical Committee of the Higher Education Funding Council for England, which no doubt you have seen and taken note of their earlier reports, and this specific issue has been addressed because it was part of the terms of reference of that committee to look at the effect of the Health Service reforms on critical mass for research. The present round of that has just been completed with this issue being addressed in detail with each medical school and each group of hospitals and trusts and that I think will be published some time in the spring. I do not think I am breaking confidence in saying that the evidence that comes from that would suggest that the real problem is with rare diseases, rare conditions. Critical mass for research on relatively common things does not seem to have been a problem, but certainly these rare conditions may need some special mechanism which obviously would need deeper thought.

(*Professor Boyd*) One hat I wear is as a purchasing authority Chair and I think—despite agreeing entirely with what John James says—there is a tremendous *de facto* pressure on a purchaser and its associated geographically proximate hospitals to minimise the number of extra contractual referrals

because it is the one bit of the budget that is flexible, and if we send a lot of patients out we have to cut from our local hospitals so there is indirect pressure on local clinicians to diminish the flow.

507. Let us move on then to the MRC-NHS Concordat. The MRC expressed disappointment over your stance on this and, on the other hand, the charities took the view that if the MRC had a concordat why could they not have one, too.

(*Professor Culyer*) On the MRC, I think our feeling was that the concordat was working quite well in practice thanks to a lot of networking and mutual sitting on committees—jaw-jaw basically. The concordat itself seemed to imply that the MRC will decide what research it would support and the NHS, as it were, has to provide whatever service support that might imply, and that did not seem to us to be a very satisfactory arrangement. Moreover, we felt that similar sorts of arrangements, if not quite the same but similar, ought to be made with other bodies, particularly those like the Wellcome that provide a tremendous amount of infrastructural support themselves for major research centres. We were needless to say very supportive of the work at the MRC, whether in clinical or Health Services Research, and I do not think any of us expected to see any of it in practice jeopardised by these new arrangements. I would personally expect to see more joint funding by the MRC and the NHS and indeed others in two, three, four way partnerships explicitly agreed as a result of the work of the Forum. On the medical research charities, I was slightly surprised by the remarks which had been made which led to your question here, I must say. The objects of the charities are plainly not matters for negotiation, and I do not think we were suggesting they were or even their interpretation might be something to be addressed in the National Forum. There are also limitations on what the MRC can support, just as there are on the R&D programme which the NHS contains. The clear understandings to which we were referring were understandings as to the criteria to be used by the NHS and the scale of NHS support to be offered for research which is sponsored by the charities. My impression is that this extension has in general been welcomed by the charities but, as to their priorities, we did not think they were for changing unless the charities themselves thought that was an appropriate thing to do, although we did see advantages in regular consultations between them and other funders in spotting developing patterns of research, engaging in foresight exercises, identifying who might be the prime supporters for particular topics or programmes, what sorts of partnership would be desirable, and the general mechanism for minimising duplication and overlap. None of these desiderata, which I hope you might agree are indeed desiderata, seems to me to constitute a threat to the autonomy of charities or indeed conflict with their charitable objectives whatever they might be. We were not, for example, implying the Wellcome should suddenly start supporting cancer research. I do not know whether any colleagues want to add to that? Our strong view, and I am quite sure I speak for my colleagues, is that we do not wish to undermine the MRC. What we want to do as far as the other medical

31 January 1995]

PROFESSOR TONY CULYER, PROFESSOR MAGGIE PEARSON,
PROFESSOR INGRID V ALLEN, PROFESSOR ROBERT BOYD
AND MR JOHN H JAMES

[Continued]

[Chairman *contd.*]

research charities are concerned is to really bring them more to the table.

Lord Perry of Walton

508. You said you thought it was working quite well with the MRC in practice, but then you went on to say you did not think it was right that it should be a requirement for the NHS to provide the infrastructure for MRC research. Why do you think it is not right?

(*Professor Culyer*) I perhaps did not express myself well. What I tried to say was that it did not seem to us to be right that a written concordat should apparently obligate the NHS to support in service terms whatever it was that the MRC decided it wanted to do on research. In practice it works all right because there is a lot of discussion, but the documentary base for it seemed to us to be unsatisfactory. Effectively what it offers the MRC from the NHS side is a blank cheque.

509. Why should it be wrong to have a blank cheque? The MRC is not likely, with peer review and all the rest of it, to want to do unsatisfactory research in the Health Service.

(*Professor Culyer*) I think the answer to that is that it takes no account of the opportunity cost of other research which the NHS ought to support but which it cannot despite a relatively high priority on the NHS side. We wanted to create a mechanism so an overall view could be taken and appropriate support provided where it seems to do the most good.

510. The MRC is being supported by Government to a certain level, should it not be supported to that level whatever it decides that proportion should be in the Health Service?

(*Professor Culyer*) No, I think, is my answer to that.

Chairman

511. To be devil's advocate, it is 16 years since I was a member of the MRC but at that time they took a great deal of account, by having members on the Council from health authorities, of the Health Department's determined priorities. They took, therefore, a broad view of the needs of the country as a whole in determining their priorities. So it would seem reasonable that that concordat should continue. Do you not feel that is still the case?

(*Professor Culyer*) My own view, my Lord Chairman, is that the written form of the contract is what is undesirable. In practice it has been operated by intelligent and sympathetic people, as I hope the recommendations which flow from the Task Force will be, and we really wanted to systematise that.

(*Professor Allen*) I would very much agree with what has been said, Lord Chairman. I think the MRC first of all has nothing to fear from what is suggested in the report. Secondly, the concordat, however imperfect in its writing, in practice is a very useful and positive model which could in modified form be used in relationships with charities. I think that is to the mutual benefit of the patient and the Health Service. I think the point we wanted to make

was that in a way we endorsed the fact that the MRC had a concordat and had definite agreements and took the NHS into account in all that it was deciding to do, and indeed that work is and should be supported, though the cake is not limitless. On the other hand, there is important work which the charities do and somehow that needs to be formalised and given priority in providing service support. It is very important to point out there is an opportunity here because the MRC in its concordat provides a training structure and training support, and indeed other kinds of infrastructure support. Some charities do that and some do not, but clearly those elements should be taken into account in arriving at any kind of way of prioritising research.

Lord Butterfield] I just wanted to make a point which I made to Dai Rees when he was here, namely that he is suffering from an enormous increase in the amount of services research which has been landed on his plate. When he was with ICI, I suppose, if a completely new product was demanded, he said, "Build me a new plant", but he is not in a position to aggregate more money to the Council to deal with this very wide and rapidly widening demand being made upon him. We had Dr Chalmers of the Cochrane Centre here this morning and clearly they are going to create an enormous demand for research of one sort or another. What Lord Perry and I are worried about is feeling the aftermath of the popularity of applying the research principle across the board to many new things and asking the poor MRC to bear the burden without some kind of relief, which would seem to be the situation.

Lord Perry of Walton] Professor Allen, you say the MRC has nothing to fear from it, I think it has everything to fear from it when the demand for research money is going to go up and up. I think there is a very real fear that the service support will not be forthcoming for the things it puts a high priority on.

Chairman] Would it not also be fair to say, and I speak as someone who has been involved with many medical charities and chairman of one for 25 years, that it would be absolutely right that the concordat principle might apply to a body such as Wellcome, which has no particular single disease interest, while the single disease charities, for example, are naturally concerned about pushing their particular corner. A similar concordat would not, I think, be right for them because they would always be wanting to pursue their specific priorities rather than those of the other bodies involved.

Lord Perry of Walton] I wholly agree that a concordat with the Wellcome would be a good thing, but that need not be a completely guaranteed provision, whereas I think the MRC is in a very special position and should have such a guarantee.

Earl of Selborne

512. You have recommended that funding R&D should be perceived as a levy on all health care purchasers determined annually and you said in 1995/96 that the *status quo* figure should be continued. We have now got a target figure of 1.5 per cent. First of all, if these figures are to be determined annually, what mechanisms would you like to see put

31 January 1995]

PROFESSOR TONY CULYER, PROFESSOR MAGGIE PEARSON,
PROFESSOR INGRID V ALLEN, PROFESSOR ROBERT BOYD
AND MR JOHN H JAMES

[Continued]

[Earl of Selborne *contd.*]

in place in order to help that determination and do you think the target figure of 1.5 per cent is in the right ballpark?

(*Mr James*) I think you have added together two separate ingredients and one might challenge whether they belong immediately together. The idea of introducing the concept of a levy was to get a greater sense of responsibility on the part of those who are purchasing services for the investment in research because we were struck by the fact that the monies that came down in different ways labelled research or research infrastructure, research grants, had arrived in the system and there was very little real ownership or understanding by many of the key players, trust managers, purchasing chief executives, of the decisions as to what that amount of money should be used for. We found a wide gulf and we found a lot of people rushing around commissioning pieces of so-called research locally that (a) were not research, and (b) were not related in any way to wider research objectives. The first idea was simply saying it is actually money that is taken out of the money for services and you should be involved in and understand the decision point which is reached. It was an extremely important point of principle. The second important point of principle was to try and remove the artificial labels often purely historical based with the different components, hence the single-funding stream. That was arrived at without regards to the view of what the total size of that levy year by year might be and the figure of 1.5 per cent which had a different origin was a figure for investment in research. I do not think that any of us know whether 1.5 per cent is what is being spent now, whether it is more or less, whether it is the right sum; and if it is not the right sum, by what means we should judge the balance between investment in services today and research into the different kind of services in the future. As to how it should be figured out annually, no, I have not been involved and I do not think my colleagues have in any deliberation of that. Annually perhaps gives the idea that it might be 1.5 this year, 1.7, 1.3 another. That is absurd obviously because of the lead times. You would want a degree of stability built into the system, but there should be an appraisal at intervals of how much of the extra resources—and we still tend, almost uniquely in Whitehall, these days to have some extra resources—should go into the research pot which seems to me to be a decision that can be addressed frequently, but I would not by that be suggesting rapid changes in direction. I do think the research committee would not expect that and I do not think the Government would have interpreted it that way.

513. Do you think perhaps you would wish to revise the recommendation to determine it annually, therefore, and make it triennial?

(*Mr James*) No, I think I would actually want to take a view every year in the CRDC as to the amount of money which we believe should be invested, but I would expect the margins of change to be small and sustainable and perhaps even then that the decision might be what should it be like in 18 months time, but even that will still be dependent upon the agreement of the Treasury as to the total amount of money in the system in a year. I think triennially is too long. It

would probably build rigidity into the system and you might actually do better out of annually rather than triennially.

Lord Butterfield

514. I understand you to say that we do not yet know how much money is being spent?

(*Mr James*) I genuinely do not think we do know in total. Including that which is implicit research going on within trusts, I do not think we do know.

515. It may be more than 1.5?

(*Mr James*) It could be.

Chairman

516. Have you any advice in response to those who have told us that because the money is at present embedded in total NHS expenditure and not separately identified, many of the health authorities are going to have great difficulty in removing the top slicing to protect the R component because the money is already allocated in providing services to patients?

(*Mr James*) I think it is going to be quite difficult with the present development of costing systems to address those concerns with any real authority that the doubters will accept. I think it is a process that would actually involve a certain amount of trust. I think none of us would want to see that done in a cavalier manner.

(*Professor Culyer*) If I might add, my Lord, it seems to me quite an urgent problem to seek to identify this implicit research because the implicit research actually costs providers of health care money which at the moment is reflected in their prices. This is one of the reasons why the major research centres have higher prices and might lose out in the internal market. The sooner it can be identified and protected and removed, therefore, from the costing element in the market for health care, the better both for health care and for research. I think that was one of the thoughts that weighed most heavily with us in seeking to identify this. If I may just say on the 1.5 per cent, that was a figure that was plucked—I think Professor Peckham in his evidence to you made much the same point—from the air. I think it probably served a useful purpose in focusing attention on R&D and the importance of increasing the commitment to it. This is certainly something we would all endorse. I think there are dangers in hanging on to it too long partly because of what Lord Butterfield has already suggested, it might turn out when we start really accounting for money that is currently spent on R&D that we are already there. I would much rather see the appropriateness of the research spend judged by what at the margin it fails to support. We do not know, unfortunately, at the margin what it fails to support in large part partly because a lot of it takes the form of this implicit research. It is very important to get the national register comprehensively established so that everybody concerned, whether they are demanders of research money or suppliers of it, can operate from a better informed base.

31 January 1995]

PROFESSOR TONY CULYER, PROFESSOR MAGGIE PEARSON,
PROFESSOR INGRID V ALLEN, PROFESSOR ROBERT BOYD
AND MR JOHN H JAMES

[Continued]

[Chairman *contd.*]

517. You have suggested that research grant applications which involve clinical services of any kind should be signed off by the NHS authority before they are submitted in order to be sure that the clinical facilities to carry out that research are available. Will that problem and the need to submit details to a national research register impose upon researchers a burden of administrative requirements which is going to make research more difficult to carry out?

(*Professor Culyer*) We have heard that point as, indeed, we read the charge that we paid mere lip service to the idea of minimising bureaucracy. I do not think it is our view that we paid mere lip service to it if only because most of us on the Task Force are ourselves researchers and would be victims of the very system and strangled by the very system that we created, as it were hoist by our own petard. On the other hand, if it is the case, as the evidence to us suggests it was the case, that failure to get a commitment from providers to meet the service base is itself an impediment to research, then it is essential that that be overcome. I think the answer lies crucially in devising a set of accounting conventions that are easy to interpret within institutions so that researchers, when they have a proposal, can go along to their finance director or whoever the appropriate person in his or her department is, and get the thing sorted out and reasonably costed in the same way that they cost anything else, like the number of research fellows they are going to appoint, and that it be done at the same time as the rest of the preparation for the research grant, the project, the programme or whatever. It is an additional burden, but it seems to me to be a necessary one and it has got to be managed in a sensible way which would of course include the NHS not demanding an unreasonable amount of detail about these things.

Chairman] After all, we have all lived with the necessity of having to have a research grant application approved by a university authority before it goes in.

Lord Perry of Walton

518. I wondered how you were going to judge what work was not worth supporting and whether this is restricted to that work which is NHS-supported work or whether it extends to work that you are merely providing a service for, in other words MRC and charity work? Since that has all been peer reviewed how do you decide it is not worth supporting?

(*Professor Culyer*) I think our view was—at least this was a point which was put to us in our evidence—that a good deal (nobody can quantify it but a good deal) of the so-called implicit research is of poor quality. It has certainly been my experience that some of it which I have been involved in has been of poor design. I might say that some of the work I have been involved in has been supported by the pharmaceutical industry. Very characteristic of this sort of work is that there is a rather limited research design put up, and then at some rather late stage in the day they decide a bit of economics would be useful to add in. Not only is it late in the day but it

turns out the initial research design was not at all good. That sort of research has never been subject to any kind of peer review. The only sort of peer review it might eventually receive is that which it would get when submitted for publication in a journal. I do not think we were—at least my feeling about it was—making statements about research which was funded out of, say, private trust funds unless it used NHS resources, whether patients or whatever, but our view was that NHS money, whether implicit or indeed any that used NHS resources, ought to be peer reviewed. We took a fairly blanket view about that. We did qualify that view with regard to the Cinderella subjects, where we thought they were probably a little too under-developed to take the full rigour of peer scrutiny. In general, we would like to see all work that uses public resources subject to peer review.

(*Professor Pearson*) In what I would describe as the rapidly developing research areas in the NHS R&D strategy, there is great enthusiasm for research where there was not hitherto, and we have to be careful not to dampen that by having an overly heavy, censorious atmosphere. I think there are very supportive mechanisms by which people interested in developing research can be prevented from doing poor quality research and getting disheartened by having peer review mechanisms which may involve some component of mentorship, where they can be advised on where their research designs can be improved and then given some funding to develop it. Certainly the Regional Small Grants Committee which I have been a member of in the old Mersey Region, had a very positive policy of being positive in moral support (and ultimately financial support if the research proposals were good enough), and working with applicants to enable them to develop their proposals to a high quality. Otherwise, what we will do is dampen the enthusiasm in precisely those areas we want to encourage.

Chairman

519. I think that last point is very important. Surely you are anxious to see that locally operated clinical research grants continue, because this is often the mechanism by means of which doctors and other members of health care professions take their first tentative steps in research, the work may not at that stage be of very high quality but may enable them to learn how ultimately to go ahead with better projects?

(*Professor Culyer*) We also wanted to see much more effective local networking between the academic research community and people in the field—clinical practitioners.

(*Professor Boyd*) I wanted to pick up Lord Nathan's question at the beginning about what the Government was trying to do to implement work in this area. They have put quite heavy funding into a national primary care research development centre which is very much multi-disciplinary and one of its roles is to bring on research across the range of disciplines involved in primary care. I felt that should be acknowledged because it is a good departmental initiative.

PROFESSOR TONY CULYER, PROFESSOR MAGGIE PEARSON,
PROFESSOR INGRID V ALLEN, PROFESSOR ROBERT BOYD
AND MR JOHN H JAMES

31 January 1995]

[Continued

[Chairman contd.]

520. Do you commend the idea which was put to us with considerable force last week by the representatives of the general practitioners, the Royal College and others, of research general practices or of sessional commitment for general practitioners to engage in research?

(*Professor Boyd*) Certainly, and there is a whole raft of things there, Lord Chairman. There are research practices, research sabbaticals, MSc in primary care research amongst others. We have to remember it is not just the GPs but also district nurses and so on in the practice.

Baroness McFarlane of Llandaff

521. I presume that this would include peer review of different research methodologies, and the sort of weight in the past on the randomised control trial is broadened out?

(*Professor Pearson*) That is an issue which partly prompted some of the comments I made about the Ethics Committee. One of my concerns is that as R&D develops into a truly multi-disciplinary enterprise with appropriate methodologies for appropriate research questions, that the referees reviewing the proposals or the applications should be humble about their competence in areas in which they may not be experienced, because it can be very damaging to people when they have a critical review from someone who has not done research of that kind themselves.

(*Professor Culyer*) There is a common presumption, and I know this has been read into our Task Force Report, that when one is speaking of quality review, quality assessment, quality assurance, peer review, one is talking about the review of projects or programmes. We were quite decidedly of the view that the system should be sufficiently flexible to support individuals who will be given a relatively free hand, and the nature of the peer judgment to be of an altogether different kind, to do with the record of that person or the promise of that person and based upon informed opinions about that person. We have in mind a very flexible and pretty comprehensive approach I think to this issue.

Chairman

522. That is the mechanism by which the MRC and other bodies pick their unit directors, of course, and by which the NHS picks its research directors. You mentioned in response to Lord Butterfield that the 1.5 per cent was plucked out of the air, do you feel the same about the 75-25 per cent split of SIFTR between teaching and research?

(*Professor Culyer*) As you will know from the evidence I sent you, that is certainly my opinion. If you try and find an answer from the supply side, from the costings side, I think you wind up with silliness. What was needed was a judgment about what the public sector, as it were, wanted to buy.

523. How would you advise us to come up with a more precise answer?

(*Professor Culyer*) I do not think there is a mechanical or technical solution to that. It is a question of judgment about priorities.

(*Mr James*) The 75-25 split was most authoritatively examined by the Review of the Resource Allocation Working Party (RAWP) formula, of which I was a member, so I was party to the decision-making process there. The original 75-25 split was derived by multiple regression analysis of an awful lot of teaching hospitals with wildly different figures. I personally would not say that you could say that it accurately defines what was necessarily incurred by way of extra costs as a result of under-graduate teaching and that as a result of research. Having made that comment, I do not feel any lack of confidence about putting 25 per cent into the research pocket and using it, although it was comprised of such wildly different apparent positions between different teaching hospitals. It also started on an assumption which I think has never been adequately tested, that the excess costs were necessarily associated with revenue plans as opposed to other factors which may or may not have been accurately picked up.

Lord Butterfield] Like a demanding population.

Lord Perry of Walton

524. The CVCP (Q172) want the role of RDRDs in relation to research facilities funding (your report paragraph 3.54) limited by "nationally agreed criteria and a nationally operated assessment system". And the CDMS (first memorandum, paragraph 3.5) have made the following proposal for distribution: "The infrastructure funds, which provide the major component of the research base, should be ring fenced. They should be channelled through the NHS regional director of R&D to a research committee established by the medical school with its academic hospital partner(s). Only in case of disagreement between the Dean of the medical school and the relevant Trust would the regional director become involved in the detailed disposition of these funds. The Dean and Trust Chief Executive would be jointly responsible for accounting for the use of the funds. This would provide a simple method of distribution and leave the decision making to those most likely to be informed about needs and opportunities". Do you see merit in these proposals? Are they compatible with your recommendations?

(*Professor Culyer*) My Lord, we agree that nationally agreed criteria should be developed. In fact I found nothing in the evidence from the CDMS which I thought inconsistent with what was in our minds, but that may be because I am not a very astute observer of what was in their's. There should certainly be nationally agreed criteria, they should be developed in consultation with all interested parties and they should be applied at the national level. We recommended in 3.60, I think, that the NHS Executive should publish the scope of the formal funding facilities, and should describe the internal systems which would have to be developed in order to secure that. The reference to ring fencing in the question I am not entirely clear about, but our recommendation was that the CRDC should advise the director of R&D on the sum to be allocated for that purpose. You will have seen that this is indeed in the new CRDC's terms of reference, I think it is item

31 January 1995]

PROFESSOR TONY CULYER, PROFESSOR MAGGIE PEARSON,
PROFESSOR INGRID V ALLEN, PROFESSOR ROBERT BOYD
AND MR JOHN H JAMES

[Continued]

[Lord Perry of Walton *contd.*]

1(c). I personally take the view that the disposition of these funds ought to be at the discretion of institutions as long as they have both to make the initial case for them and when successful provide an account of what they have been supporting. So the suggestions from the CDMS seemed to me to be quite consistent with what the Task Force had in its mind. I might just add, in accounting for what one does I would hope very much that the system is not excessively specific. When you decide what to give an institution or a group in the way of this form of support I hope very much that they will have a lot of discretion that will enable them, for example, to back entirely new and rather risky ideas.

Chairman

525. Do you see any virtue in a suggestion that once you have identified at regional level a figure for the R component of SIFTR, at the disposal of such a Committee as recommended here, that the money might be divided into two different pots: one pot for health services research which would be supportive of the kind of projects that we have been talking about earlier and another pot which would go towards covering the excess costs of the major centres of excellence to enable them to be involved in bio-medical research?

(*Professor Culyer*) My Lord, we did recommend that there should be a specific pot for the service support element. Whether one wants to have further pots which would, as it were, protect clinical research from Health Service's research—we get into these definitional problem as to which goes into which category—I am not sure myself. My own view about it would be that I think things that are at risk need to be ring fenced and protected, but if there is not a particular risk I must confess I have an instinct against earmarking and ring fencing because it reduces people's discretion to exercise their judgement on the basis of the best advice they are getting.

(*Professor Boyd*) I think you have touched on one of the most important issues with this question. Just before answering that, perhaps I can refer back to the earlier part of your question which raises an important technical point. In the quality assessment of facilities to support I think great care has to be paid to the technical detail, that it should be done around individual universities (usually medical schools) conducting research in provider units, and not round individual provider units. I think if facilities for support are allocated to individual provider units that would be a recipe for stagnation, in-fighting and failure to progress and re-organise between them within a single conurbation.

526. Even with the Research Assessment Exercise?

(*Professor Boyd*) That is exactly the point I am making. As with the HEFC research selectivity exercise the assessment needs to centre on a university and its associated provider institutions, not on individual provider institutions; a very important point. That is a technical one. On your general question, like Professor Culyer I feel one should aim for a seamless robe and non-ring fencing between the bio-medical, clinical and Health

Service's research, but I am very worried that some of the points we made in paragraphs 3.7 to 3.15 of the Report might not be sufficiently clearly responded to. This refers to the point I made in my written submission to you of the need to re-balance the strategy of the NHS R&D programme in the light of the single funding stream. I think this is a very important point. If you read the strategy as it lies at the moment, it is clearly one devised for complementarity to an existing strong clinical science programme involving NHS support. With single funding the strategy has, in my view, to be re-balanced to make sure that it explicitly goes to support the service costs of clinical and bio-medical research as well as that of Health Service's research. Without that re-balancing if the current strategy is wrongly interpreted downstream there is a small but finite risk of destroying something we have built up over 200 years. I think it is a very important point. Mr Makower indicated a subsidiary question about specific examples of concern in this area and I have prepared a short written addendum which illustrates just three programmes in the patch where I happen to work which were discontinued in order to allow funds to be released for new NHS R&D. One needs to look at the overall strategy and make sure it is re-balanced.

Lord Perry of Walton

527. I could not agree more with the need to re-balance. That is the diagnosis. Who does the re-balancing?

(*Professor Boyd*) I think there are two elements to it: one is clarity, and actually in my written submission I suggested a little re-wording of the NHS R&D strategy to meet that point. There are other ways of doing that. It should be clearly understood at the top of the shop and by all downstream from it that the strategy comprises both the clinical and the health services wings of the research endeavour. The other one relates back to the point that we discussed a few moments ago about the 1.5 per cent. I actually think we are taking on a very exciting new agenda with Cochrane, with Health Service's research, but my own private feeling is we cannot quite do that by shedding the weaker bits of clinical science. I think if we are going to keep clinical research strong and do a proper job by Health Service research, by Cochrane, by the new things Maggie Pearson is referring to, by primary care, we do need some increase in the envelope that is round the 1.5 per cent or whatever the historical overall figure is.

Lord Butterfield

528. Is the paper you referred to the one dated 23 January?

(*Professor Boyd*) Yes, and I have got a subsidiary two-pager that I will hand in to Mr Makower, if I may.

31 January 1995]

PROFESSOR TONY CULYER, PROFESSOR MAGGIE PEARSON,
PROFESSOR INGRID V ALLEN, PROFESSOR ROBERT BOYD
AND MR JOHN H JAMES

[Continued]

Chairman

529. To whom would the actual funding cheque go? Would it go, as you suggest, to the dean of the medical school or would it go to the health authority covering a district when there are a series of different trusts?

(*Professor Boyd*) I think that is a very interesting point and John James I know has some views. I think probably it needs some sort of joint signing off, between the university and a lead purchaser probably in the geographical patch which has the single biggest contract with provider institutions. John might have a clearer view.

(*Mr James*) I think there are three parties who have got to sign it off: they are the medical school or whatever, the academic framework, the trusts which will actually have to provide the service support, and the main purchasers upon whom the supply of patients depends. My own view then is that to whom the cheque is made out probably answers itself. Where it is to subsidise the cost of services provided by a hospital to reduce the price then it must go to that hospital by way of subsidy. If it is to employ researchers it must go in through the medical school route. It is not always going to be clear-cut, which is really why I would like to see an agreement that all parties had signed up to which was based upon a clear understanding as to the flows.

Lord Butterfield] What about when you are supporting the patients, is that money going to have to go to the GPs? I am being rather detailed, but it is rather important to know. I think that is very important that you are covering the patients, but I am not quite sure who is going to take on that expense.

530. Supposing you have a fundholding practice, where does it go?

(*Mr James*) The fundholding practices are the most difficult to take account of in here because quite clearly if health authorities wished to direct patients in one way and do not have the means to ensure that they go there then an agreement is not going to be worth the paper it is written on. If I as a health authority ignore the views of non-fundholding general practitioners I likewise cannot do that. It is incumbent upon all of us who head commissioning agencies, whatever we call them, to work with GPs to ensure that there is not a conflict of this kind. It can be done. I do not actually think fundholding makes it easier to achieve because it removes a lever but it is not the decisive problem.

(*Professor Boyd*) If it were feasible, which I doubt, Lord Chairman, I would say send it to the university with a medical school, or to a non-medical school university where research is associated with it.

531. As a former dean speaking to another former dean, I can understand your point!

(*Professor Pearson*) I think the question of GP fundholding is a very interesting one. With the new total purchasing pilots, where there is a clear sense that there may be an incentive for fundholders to move work from certain provider units because there are incentives to keep the savings, the situation becomes more complex.

532. There is nothing to stop a fundholding practice having one, or more, partners with one or two research sessions paid by the university.

(*Professor Pearson*) There is not, but when we were deliberating on the Culyer Committee certain issues were identified which would have to be looked at carefully. I take your point about some research sessions but I think there are very complex issues which need to be watched for with some of the rapid changes in purchasing.

(*Professor Culyer*) There was a problem specifically with facility support in fundholding general practices, but I do not think there was a particular problem—

533.—with the salaries, no. It has been put to us that in the United States certainly, and to a limited extent already in this country, certain hospitals which have a major research programme are designating research beds, clinical research facilities with excess service costs paid from non-NHS sources. Do you see this as being a possible mechanism for protecting programmes of research in former special health authority hospitals or in other major teaching hospitals and centres of excellence? The service costs of one or two beds which can be used in a special unit for research purposes might be covered from the R&D budget, or alternatively the service costs of one or more out-patient sessions for research purposes might be covered in that way?

(*Professor Culyer*) My answer to that would be, yes. We made no recommendations about research beds. They are a very specific thing and it would be wrong now to suggest that we support them as an appropriate way forward for some research centres. It seems to me that research beds are very much a matter for facility support. We have heard them argued for, we had evidence concerning them and I suppose our expectation would be that where the case for them was good, money would be allocated to them and internally managed within the institution to ensure that that money indeed went to support such facilities. They seem to me to be just one example of many different kinds of facility support and it seems inappropriate for us to try and evaluate a case for them now which has yet, frankly, to be fully made and which can really only be evaluated properly alongside all the other sorts of components which might be put into a package which would constitute an institution's bid for facility support. In principle, yes; in practice, I think it would depend upon the strength of the case made and what other demands there were on the money. Professor Allen wants to come in, I think?

(*Professor Allen*) It was really almost a question, because it states here that these are being paid for from non-NHS sources.

534. We are aware of one or two limited examples of where research beds are being paid for by major grants from pharmaceutical companies.

(*Professor Allen*) I certainly would not be against the principle, and I think it could be developed, but I would say with caution. Certainly it would be sad if it became a necessity, particularly with certain rare diseases, that the way funding for research could be achieved was with this kind of infrastructure going with the funding. I think it needs a cautious kind of approach, particularly if funding is coming from outside the NHS.

535. Certain witnesses have suggested to us that consultants who in the past may have been involved

31 January 1995]

PROFESSOR TONY CULYER, PROFESSOR MAGGIE PEARSON,
 PROFESSOR INGRID V ALLEN, PROFESSOR ROBERT BOYD
 AND MR JOHN H JAMES

[Continued]

[Chairman *contd.*]

in considerable programmes of research are experiencing pressure from managers to increase their through-put of patients on a purely service basis and are not being able to pursue their research programmes, either because they are too much committed or too heavily pressed on clinical work, or because they do not have the beds or out-patient clinics in which those research projects can be carried out.

(*Professor Allen*) Ideally this kind of stress should be considered as part of the service support of the NHS rather than coming from independent sources.

Lord Butterfield

536. Professor Culyer, you will know that it has been suggested that your working party failed to draw a clear distinction between the funding needed for infrastructure of the university hospitals for their traditional, far-reaching, long-term clinical research, and on the other hand the resources needed to support the direct and indirect costs of the new NHS R&D initiative. You know of course that others have expressed similar sorts of concerns that the procedures you propose will not protect curiosity-driven clinical research from NHS internal market pressures on the one hand and the directed NHS R&D programme on the other hand. Are those fair comments?

(*Professor Culyer*) We were extremely anxious to protect research. Professor Boyd has already referred to a seamless robe and it is invidious really to draw distinctions between basic scientific research and clinical research and Health Service research. The whole thing is best seen as a seamless robe, as a continuum, on which there is on-going interaction. I would personally very much regret any misapplication of our principles which was fundamentally destructive of some of our great institutions. On the other hand, I do not think we can entertain an open-ended commitment. We received a great deal of evidence to suggest the current SIFTR support which went to institutions was not getting through, in the views of researchers, to researchers. So the existing system did not appear to be doing the job it was set up to do. Therefore we came to the view that we needed to have much more explicit cases made for the kind of research that facility support would support, and that would include giving people an opportunity to make the sort of case that I think might be derived from the form of words you have just used. Where there are very important synergies, if I can use that awful modern managerial term, between different sorts of research, or indeed going even further between teaching and research, I think that has to be recognised. I see no reason why those sorts of arguments should not be made in bids for facility research which would then explain how this tranche of money for the research side was going to be used in a complementary fashion to money which came from the Funding Council element or whatever to support an overall activity. It seems to me this is an example of what we were trying to create, a mechanism which was enabling, which would enable people to make a case and make it not necessarily in a quantitative way, because some of these cases are

inherently qualitative, about the quality of research life and what it is to work in a research environment and create a research environment which is going to be successful. It seems to me we need to give people an opportunity in order for them to make those cases. We have been interpreted, as it were, as ruling out certain kinds of support and I think that is not the case, we are not trying to rule out, we are trying to rule in but at the same time provide a kind of language in which a dialogue can take place in which reasonable people can explain what it is they are aspiring to and appropriate decisions can then be made.

Baroness Perry of Southwark

537. I was interested in Professor Pearson's memorandum and its references to the importance of training which I thoroughly support and agree with. Would you like to say a little bit more about why you think the relationship is so crucial and who are the people you most believe need the extra training?

(*Professor Pearson*) The first thing I would want to say is I do think this is a vast issue which needs to be looked at thoroughly and I could not possibly do justice to it in an afternoon. It was outside our remit and I think we are all conscious that there were issues there that we could not stray into. We cannot have a knowledge-based Health Service unless people are trained in how to use the knowledge. That is the nub of the issue. We can have a lot of clinical research generating all sorts of new knowledge, but if the people in training posts do not have the time to read the journals, are not taught how to put in place the literature, are not taught to therefore decide which knowledge, which may have been peer reviewed, nevertheless is more valid than others, then I think we will not actually achieve the purpose of the R&D strategy. I think perhaps because of the relative infancy of the R&D strategy, links with training have not yet been established and they have been less established than with audit. I would like to think of there being a key triangle which underpins programmes of professional development which has R&D on one side, audit on another, and education and training on the third side. They are obviously symbiotic in many ways and need to work together and reinforce each other. There are various dimensions to it. There is a need for research training on undergraduate courses. I think we can do it too heavily and too quickly if we are not careful. In the medical school at Liverpool we have medical students, nursing students and a range of professions related to medicine, apart from speech therapy, and I think we have to be judicious about when we introduce undergraduates to research. However, we need to boost that enthusiasm and that critical awareness very early on, and encourage students not to take things for granted but to want to see the evidence.

538. Would you be saying that you need two levels of this research training or at least this training related to R&D: one is for the whole range of the medical profession itself and paramedical professions to be introduced to the principle of research during their training, but you also want the

31 January 1995]

PROFESSOR TONY CULYER, PROFESSOR MAGGIE PEARSON,
PROFESSOR INGRID V ALLEN, PROFESSOR ROBERT BOYD
AND MR JOHN H JAMES

[Continued]

[Baroness Perry of Southwark *contd.*]

users of research—I think one of Professor Culyer's recommendations was that the Chairs of regions and authorities ought to be given a specific target of research—trained in that as well which would be quite a different order of training, would it not?

(*Professor Pearson*) If I could just stick with the professionals for a minute, I think there is a need for R&D to be well linked in with postgraduate professional training programmes. I have mentioned in my evidence an example from the former Mersey region that the postgraduate dean there actually has a target, he tells me, of trying to get eight out of the 40 hours of postgraduate time for formal education. He would like to see that linked to the fruits of the R&D strategy but also training about research and development. The other professions have different routes. There is the second issue, which I will refer to Professor Culyer, about other people responsible for commissioning and providing services also being research proficient at an appropriate level. Obviously we do not want everybody to be Nobel Prize winners, but we do need people to understand what research can do and also what it cannot do.

(*Professor Culyer*) What needs to be done is to adopt a rather more analytical approach to this whole issue of training. We need to train researchers particularly in some areas that were identified in the Report. This is being reviewed by the Department. We also need to train what I think have been referred to as users—and there is more than one kind of user and they will need different sorts of training. If you are a purchaser, which is one customer for R&D, a different sort of training would be appropriate than for some of the professionals when one is concerned about implementing R&D in clinical practice, for example, or nursing practice, whatever it may be. Similarly, we need to train commissioners of research to identify what is a researchable problem, for example. There are a lot of training issues there and I think the helpful way forward is to get it unpicked and identify the clients, as it were.

(*Professor Boyd*) I have mentioned in my written evidence that we have got a long way to go in getting the different professionals involved in Health Service research to really feel confident, in really working together. There are a whole lot of difficulties, some of which are addressable. There is the difficulty of salary differentials between medical personnel and non-medical, of career security, of esteem, of anti-doctor and anti medical model attitudes, a whole lot of things. Some of them are difficult to address, but for example, even if salary levels are difficult, degrees of security of employment might be more equal and, at the micro-medium level, managers of research need to work very hard to get the added value of getting different trades to work closely together in research.

(*Professor Pearson*) I think there are issues about training and research. The point I was making was really that we need to make sure that the fruits of the research are fed into the training of professionals.

Baroness McFarlane of Llandarf

539. I think this question is very much linked with the lack of sufficiently established research capability in many of these professions. I am wondering what

evidence you have for this because it seems to me that it is now well on 30 years since some of the first clinical nursing research projects were undertaken and I am wondering how you identify where we have been going wrong in the education of these professions?

(*Professor Pearson*) I do not think we have been going wrong. The fact is we have got an enormous task. I think the professions themselves recognise the need to develop their own research capability. The therapy professions developed a response to the Report on the strategy for developing nursing research, so they themselves recognise it. This is not a criticism of the professions. I think the professions have come a long way in getting into higher education and developing knowledge-based practice. I would not doubt at all the quality of the researchers that there are, but I would like to see more. When I advertise posts in my unit—and I now have a range of professions working in the unit—I would like to see more of them who actually had health professional training. I think it is just a matter of time and support to develop research.

Chairman

540. Is funding for research, for training fellowships or for research posts difficult to come by?

(*Professor Pearson*) Yes, in short. I hope very much that the MRC and the RHA training fellowships will be very careful to ensure that they do include professions other than medicine in those and that in assessing people they do not expect them all to be coming from the randomised control trial tradition.

Baroness Perry of Southwark

541. I really wondered what sort of training you wanted people to have. What would you want to see them doing that they do not do now? I am a little puzzled as to what this lack that you have identified is.

(*Professor Pearson*) The professions themselves have their own view of their need to develop their research capability. I think there are two issues: one is that I would like to think—and I see this on the Small Grants Committee in the region and in my own professional practice—there were more people wanting to do research in those professions, perhaps taking a sideways move in their career, doing some research and then going back to clinical practice. It is much more difficult for the professions other than medicine to combine clinical practice and an academic career. In fact, it is well nigh impossible. There is a second issue: again I do not question the qualifications which the researchers have, but we know there is a national shortage of health economists. Some colleagues, including colleagues in Liverpool, have real problems recruiting health economists. They are all in York with Professor Culyer! The other issue is statisticians again. I have colleagues who are statisticians who provide advice to researchers and they are absolutely swamped with requests for support. Professor Culyer has mentioned that the Department of health is already

31 January 1995]

PROFESSOR TONY CULYER, PROFESSOR MAGGIE PEARSON,
PROFESSOR INGRID V ALLEN, PROFESSOR ROBERT BOYD
AND MR JOHN H JAMES

[Continued]

[Baroness Perry of Southwark *contd.*]

taking a look at this and I would not want to preempt their findings at all. I know the professions themselves feel that they would like to develop the capability to the quality which is currently in rather short supply.

(*Professor Culyer*) I think there are both qualitative and quantitative problems. The quantitative problem is that there are just not enough people to do the work and, as the work is growing, that problem becomes more acute. The Department of Health has been supportive in selective areas including the field of health economics, in conjunction with the ESRC, which has been very productive in producing some extremely well-trained people. I think we probably need more of that for some of these other fields. I think attention does also need to be paid to the qualitative side of some of the training. Without wishing to enter a serious note of dissent from you, Maggie, it would seem to me that the sort of disciplines of epidemiology and biostatistics, for example, that are central to an evaluative culture and doing much Health Service research of the sort that we all want to see more of, are not sufficiently well taught or frequently taught. I should not say well taught, that implies something about the adequacy of the teachers. They are not sufficiently taught in some of these areas, which is a qualitative point.

(*Professor Pearson*) There is the point of there being the people to do the teaching. Statistics and epidemiology may be taught by people who are not specialists in that field themselves because there is not a sufficient supply of people to do the teaching.

Chairman

542. A common experience. If you wish to teach psychology and behavioural sciences to medical students, you get clinical psychologists to do it and not professional "pure" psychologists. This is a very common experience.

(*Professor Allen*) There is a slight inherent short-term danger in looking at the relationships between professions. I very much agree with Tony, that one needs to sit back and dissect the issue. This is not really about professions, it is about expertise and forms of science and disciplines. All that was said in the questioning about the non-medical professions can actually be said of medicine. If we could somehow get into the thinking of this idea of looking at the discipline needs and then the training of professions, and then secondarily how they are interacted and developed accordingly, I am sure this is the way forward. Actually one of the messes we are in is because we tried to relate this training to professional training, and I think we should try to break free from that.

Baroness Perry of Southwark

543. A person attracted to the nursing profession may not be the kind of person at all who is attracted to or suitable for doing advanced research. You do not necessarily always want to use the same people.

(*Professor Allen*) That is true of medicine also.

(*Professor Pearson*) I am not talking about people being in professional "drainpipes". What I am saying is that there are certain training routes in research which have been more open to medical practitioners and to others. I am someone who benefited very much from the Department of Health nurse post-doctoral fellowship scheme. I do not consider myself primarily as a nurse, but as somebody who has had experience in the Health Service, and that whole training scheme enabled me to move into a wider area of Health Service research. I think it was enormously fruitful and my unit has developed as a result. So it is not a question of separating professions at all.

Lord Perry of Walton] I do not know enough about the other professions, but I know something about medicine and I know a very large proportion of the doctors who qualify are (a) not interested and (b) not competent to do research. I suspect the same is true in all the others. The difficulty that I see is that the demand to do research comes from two things from people who should not be doing it. One is that it has a glamour it does not deserve because it is "5 per cent inspiration and 95 per cent perspiration", and the second is the demand to publish because of promotion prospects which, if we could get rid of, would be a good thing. Are we not over-doing looking at training everybody in research methodology?

Chairman] There is no question at all from past experience that some of the finest clinicians are those who have learned through research to implement the products of that research in their clinical practice, and I think it does often help enormously to improve the standard of clinical care.

Lord Perry of Walton] Some of them, yes!

Chairman

544. Professor Boyd, you said there are instances where the NHS R&D strategy has been applied to favour new areas of research, currently of speculative quality, at the expense of well-reviewed, high quality, relevant long-term research. Would you like to give us some examples?

(*Professor Boyd*) When I say "speculative" I mean it not in the pejorative sense but in the sense of not yet proven to be beneficial. An example detailed in my written submission was in the now defunct North Western Regional Health Authority. It had a research infrastructure scheme which was discontinued with effect from this year. The decision to discontinue was taken before the amalgamation of that region into the new combined North West region. Most of the money for that Research Infrastructure Scheme was spent in support of the teaching hospitals associated with Manchester Medical School, some six in total. One trust taken as an example had 0.49 million a year of NHS money devoted to infrastructure support of its clinical research. That funded 17 on-going research programmes of an infrastructural nature and I have picked out three examples for you that have now had their funding ceased: one is a statistician in psychiatry, in a department which was in a unit of assessment rated five in the last exercise which has MRC support, and this statistician played, in their

31 January 1995]

PROFESSOR TONY CULYER, PROFESSOR MAGGIE PEARSON,
PROFESSOR INGRID V ALLEN, PROFESSOR ROBERT BOYD
AND MR JOHN H JAMES

[Continued]

[Chairman *contd.*]

view, an important role in their research portfolio. Another example is a technician in research to do with bone disease in a group supported by an MRC programme grant in a department which rated four in the last exercise; and a third example is in a group studying placental transport in abnormal pregnancy again supported by the MRC through a five-year special project grant. Those and 14 other programmes have had their funding removed with effect from this year to enable money to be released into new areas of Health Service's research. I have also submitted to you the Research and Development Plan of the new North West Region, which, I should emphasise, did not make the decision to stop that funding but is now responsible for any such research support. It is an extremely good document, but one that focuses on what I referred to earlier as complementarity research, e.g. Health Service's research, picking up very important new issues. It contributes, for example, support to the National Primary Care Research and Development Centre. It supports the development of technical skills in Health Service's research such as statistics of a generic sort and audit and basic training in Health Service's R&D, but it does not have any particular focus on support for clinical research of the type whose funding was stopped.

545. Professor Culyer, we are just about coming to the end of our time. You said you had some valuable insights which did not find their way into the Report. Would you care to share these with us?

(Professor Culyer) I offered them to you, my Lord, a little earlier in some selected quotations from our evidence. Unfortunately, our evidence was sought in confidence. I very much regret we are not really in a position to offer you all seven volumes of it so that you can take it away and digest it. If I might answer that one in writing subsequently?

546. That would be very helpful. Then we have heard your views about explicit targeting for regions and authorities. Do you wish to amplify that at all?

(Professor Culyer) No, other than it seems to me to be a cause for regret that explicit questions about the steps being taken to implement evidence-based practice in the NHS are not there. Similarly, it is a pity that questions about what has been done to support R&D are not there for chief executives and chairs.

(Mr James) Can I offer a comment as a chief executive to whom that is obviously directed? This is an entirely personal reaction. I do not think that people like me can be expert in everything. The most dangerous person is somebody who believes they are. I think the key thing is that both chairs and chief executives should understand the research agenda that is going on around them and that they should not unwittingly do it harm. The idea that they should

seriously add to all of the lists of things in which they are deemed to be expert a significant capability to judge that I think would be beyond the competence of myself and I think of most others doing my kind of job and probably would actually be wrong to pretend that we could do it.

(Professor Culyer) That is perfectly correct, but it was not my intention you should become expert in this but to answer questions about what you are doing about it, which might involve you ensuring there is somebody with expertise in your organisation.

Earl of Selborne] That rather well describes the role of their Lordships' Committees!

547. One anxiety is that we understand in the new Health Authorities Bill, which is at present working its way through the Commons, the statutory role of professional advisory committees may no longer be implemented as they were in the past. Is that something which would concern you? Surely in order to be able to fulfil your responsibilities as chief executives and chairs of authorities, good quality advice from the professionals is important?

(Mr James) Yes. I would expect to get that regardless of the decision on the role of the statutory committees.

(Professor Boyd) I wanted to raise one other point which is not on your agenda of questions, Lord Chairman, which I do with some hesitancy but which might be an opportunity to run a slight concern I have across your Lordships. At the moment most research using NHS facilities is driven by the traditional rules of openness and publishability through the university tradition and the HEFCE rules on publication not being withheld. The NHS service support for such research has come in an uncontractual way through SHA and SIFTR funding. I am conscious that some contracts or draft contracts with the Department of Health for directly commissioned research may include the Secretary of State's right to prevent publication. While it is not directly related to Culyer, I think it is something which is of potential concern which could be a retrogressive step as we move to an explicit single funding stream for the NHS side of support.

548. We thank you very much not only for your report but also following it through with this very interesting session.

(Professor Culyer) If there are further questions you have for us, Lord Chairman, I would be happy to act as a kind of orchestrator from our side and, if there is a consensus, seek to establish it and communicate it to you.

Chairman] Thank you very much indeed for that offer.

31 January 1995]

[Continued

Supplementary note from Professor Culyer**COMMUNITY SETTINGS AND THE DISCIPLINES OF HEALTH SERVICES RESEARCH**

Before the Task Force I was not myself fully aware of the low state of R&D in community settings (both quantitatively and qualitatively). We received a lot of evidence on this. Nor, beyond the health services research disciplines with which I am most frequently personally concerned (health economics and epidemiology), was I aware of the shortage of skilled people in sufficient numbers and the unsatisfactory nature of their employment patterns and career prospects. Although my own discipline of health economics itself has a strong conceptual and empirical base, that seems to be much less true of other disciplines, including some social sciences (a matter that has concerned the ESRC) and the nursing and therapy professions. Across all of them, moreover, the career problems for researchers are very similar. These are very large topics, to which we were not able to give time, but we recommended that they be pursued. They are currently being reviewed by the Department of Health. I have addressed some of these issues in a paper I gave recently to the Association of DH Funded Research Workers, a copy of which I would be happy to let your Lordships have.

Here are some (unattributed) remarks given to us in evidence from a variety of sources:

There are considerable inadequacies in status, research career prospects and training for non-medical and medical researchers. There is a ridiculously wide discrepancy in the pay offered for non-medical and medical researchers applying for the same job.

The single most important deficiency is the lack of research training opportunities for general practitioners who are enthusiastic to undertake research in general practice in the future. Training posts, full time and part time, are urgently needed in all regions.

Historically, general practice/primary care has developed as a clinical service rather than an academically-led discipline, and its economic orientation to the independent contractor status has resulted in the evolution of a culture which is not supportive of research.

General practice is short of role models and leaders who can be competent and effective advocates for general practice research.

At present no career structure exists for nurses in research. This is exacerbated by the traditional view that nursing is subservient to medicine, thus limiting opportunities for nurses to study for doctoral level degrees.

The main outstanding problem is a lack of balance in R&D. Most British research is focused on and funded on the basis of the importance of laboratory techniques based on the bio-medical model of disease. The College accepts this is of great, but not exclusive, importance.

In addition, members (especially Professor Pearson) each brought their own experience to the table, from which some of us emerged much better educated than we had previously been.

MINUTES OF EVIDENCE
TAKEN BEFORE
**THE SELECT COMMITTEE ON SCIENCE
AND TECHNOLOGY**
(SUB-COMMITTEE I MEDICAL RESEARCH
AND THE NHS REFORMS)

Tuesday 7 February 1995

NHS EXECUTIVE
Mr Colin Reeves and Dr Graham Winyard
DR MALCOLM GREEN

Printed pursuant to the Order of the House of Lords of 22nd November 1994

LONDON : HMSO

£6.65 net

TUESDAY 7 FEBRUARY 1995

Present:

Butterfield, L.	Perry of Walton, L.
Gregson, L.	Selborne, E.
McFarlane of Llandaff, B.	Walton of Detchant, L.
Nathan, L.	(Chairman)

Letter from the NHS Director of R&D

Thank you for your letters of 8 and 15 December. Our responses to the further questions for the enquiry are as follows:

8 December:

Appointment of Regional Directors of Research and Development.

The following Regional Directors of Research and Development were appointed following a limited competition in line with the guidance issued following the Functions and Manpower report:

Professor A Haines, North Thames
Professor G Alberti, Northern and Yorkshire
Professor T Stacey, South Thames
Professor S Frankel, South and West
Dr Muir Gray, Anglia and Oxford

These appointments are effective immediately and I attach a copy of the job description issued at the time that applications were invited. As set out at paragraph 31 of the job description, the posts are full-time, but part time appointments are possible during the transition from Regional Health Authorities to regional office working within the NHS Executive where this is in the interests of the RHA/regional office and the postholder. Such flexibility has been allowed in making the new appointments. Close working with the Universities and with other bodies with which we share an interest in medical and health services research will continue to be a feature of the programme.

The remaining three posts were not filled and the Acting Directors will continue in post until an open competition is held in 1995.

The Acting Directors are:

Professor A Breckenridge, North Western RHA
Professor A McNeish, West Midlands RHA
Dr P Cooke, Trent RHA

15 December:

QUESTION 1

What is the role of District Health Authorities? Do they have any role in respect of research or support for research?

ANSWER

1. The 110 District Health Authorities (DHAs) in England are responsible for assessing the health needs of their local population and securing services to meet those needs from their available resources. As part of this process health authorities should be taking systematic action to seek **and act** on the views of GPs, the wider public and their representatives about where they would prefer to be treated and where contracts should be placed. In addition, DHAs hold a limited budget in order to meet the cost of patients referred to hospitals with which they do not have a contract.

2. DHAs act as agents for the public by:

- assessing people's health needs and developing local strategies for improving health;
- targeting resources, through the contracts they let with providers of health care, on high quality, value for money services;

7 February 1995]

[Continued

- bringing pressure to bear on providers to raise the quality of care and efficiency by setting standards, monitoring performance and exercising choice between competing providers;
- working with and influencing other statutory and voluntary organisations to improve people's health.

3. The functions for District Health Authorities in the NHS R&D strategy, including support for research, are set out in "R&D in the New NHS", copies of which have been sent to the Committee. Table 1 in that documents summarises their functions, and this is attached (*printed at p 20*).

QUESTION 2

How many NHS Trusts are now in being? Of those, how many are in receipt of SIFTR? If possible please list them, with the amounts received in the last three years. Please give equivalent information for "non-SIFTR".

ANSWER

1. There are currently 419 NHS Trusts. Information about the number of Trusts in receipt of SIFTR is not collected centrally. SIFTR is allocated to Regional Health Authorities on the basis of their number of undergraduate clinical medical and dental students. Regions administer this money in line with general Departmental guidance which requires service support contracts to be in place.

2. The non-SIFTR awards are awarded centrally by the Department. It is available only to hospitals which are not SHAs or eligible for SIFTR because they do no undergraduate teaching. To qualify in any one year, units have to attract external research grants which equal or exceed £100,000 and one per cent of their overall budgets. Five NHS Trust hospitals successfully applied for non-SIFTR awards in 1994-95:

Harefield Hospital NHS Trust	£548,151
Mount Vernon and Watford Hospitals NHS Trust	£994,160
Robert Jones and Agnes Hunt NHS Trust	£75,987
Royal National Hospital for Rheumatic Diseases NHS Trust	£131,325
North Staffordshire Hospitals NHS Trust	£330,377

3. All qualifying hospitals, apart from North Staffordshire, qualified for payment last year (1993-94) and the previous year (1992-93).

Please let me know if you need any further information.

Annex A

Regional Director of Research and Development

JOB DESCRIPTION

1. The report *Managing the New NHS: Functions and Responsibilities in the New NHS* states that each regional office of the NHS Executive will include a Regional Director of Research and Development (RDRD).

2. The RDRD is a member of the top management team of the RHA/regional office in recognition of R&D's integrated functions along with the other top management posts.

3. The RDRD leads the Research and Development Directorate in the RHA/regional office and is managerially responsible for all staff employed in that Directorate.

4. The RDRD contributes to other work led by the Research and Development Directorate in the Headquarters of the NHS Executive, as agreed between the Regional Director and the DRD.

JOB SUMMARY

5. The RDRD leads R & D in the RHA/regional office and the geographical region it serves by:
- (i) ensuring that the R & D needs of the NHS in the region are identified;
 - (ii) ensuring that funds for R & D, for service support for research, and for training for research which the RHA/regional office is responsible for administering are appropriately targeted and accounted for;
 - (iii) ensuring that NHS decision makers are helped to seek out and make use of R & D findings and that the service is held to account for its use of R & D findings and support for R & D in the NHS;
 - (iv) ensuring that all work of the RHA/regional office is informed by the R & D Strategy and relevant R & D findings;

7 February 1995]

[Continued

- (v) promoting the culture of a knowledge-based NHS, both in the RHA/regional office and in the parts of the NHS for which it is responsible.

KEY RESPONSIBILITIES

Identifying research needs:

6. Lead work in R&D networks to promote awareness of the NHS R&D Programme, and of the importance of R&D findings with particular emphasis on how the results of R&D can be accessed and used.

7. Work with contacts nominated by each purchaser and provider through its chief executive and by other appropriate bodies (e.g. Universities, the wider research community, patient representatives and industry) to identify R&D needs for discussion in a reconstituted regional R&D Committee.

8. Appoint members of the regional R&D Committee and either chair its meetings or appoint an appropriate chair from amongst its members.

9. Ensure that the research needs identified through R & D networks and the reconstituted regional R & D Committee are communicated to CRDC advisory groups and feed into other NHS commissioned work.

Administration of funds

10. Appoint the chair and members of the responsive mode and commissioning committees.

11. Ensure that grants for R & D and for research training are awarded and administered in accordance with the advice of the responsive mode and commissioning committees.

12. Subject to the outcome of discussions on the Culyer Report, ensure that facilities contracts for service support for R & D to providers are let and managed according to nationally agreed criteria.

13. Ensure that the administration of funds which support R & D complies with financial accounting standards and is well managed.

14. Ensure the provision of returns and forward plans for funding for R & D, research training, and service support for research.

15. Ensure that the Project Register System in regional office stations is managed and maintained according to nationally agreed standards.

Use, and Accountability for Use, of R & D Findings

16. Lead work in R & D networks to promote awareness of the importance of R & D findings, where to locate information on them, and how to use them.

17. Work with other members of the regional office top management team including the Regional Directors of Public Health and Finance and with the Postgraduate Dean(s) and with others inside and outside the regional office to promote

- the culture of a knowledge-based NHS, in the RHA/regional office and, more widely, to the NHS and its users throughout the region
- promote high quality cost effective clinical practice

through the development and use by Health Authorities, Trusts and GPs of approaches such as:

- knowledge based purchasing and servicing delivery (including outcome measures);
- clinical audit;
- integration of primary and secondary care;
- postgraduate and continuing education.

18. Ensure that information flows between the NHS Executive, the component parts of the R & D Information Systems Strategy, and the field are well managed.

19. Contribute to the development of the performance management role of the RHA/regional office.

20. Support the Regional Director in holding purchasers to account for their use of R & D findings and, through non-managerial R & D networks, for holding providers to account for their use of R & D findings.

21. Support the Regional Director in holding providers to account for the provision of support for NHS R & D.

7 February 1995]

[Continued

Integration of R & D with regional office functions

22. Attend meetings of the top management team of the RHA/regional office and ensure discussions and decisions there are informed by the R & D strategy and R & D findings.

23. Promote dialogue throughout the RHA/regional office so that others in the RHA/regional office take account of the R & D strategy and R & D findings in their work.

Promote a knowledge-based NHS

24. Seek out opportunities to promote the R & D Strategy and its benefits to meetings of NHS managers and clinicians and of the research community in the region.

25. Ensure the promotion of dialogue between purchasers and providers in the region on the need to support innovation, systematic development and evaluation of services.

Other executive responsibilities

26. Ensure that input is provided as required to the work of the NHS Executive, for example on:

- plans and reports;
- briefing;
- parliamentary business.

27. Ensure that views and information are provided to DRD as required on progress in relation to all of the above.

ACCOUNTABILITY

28. For work on behalf of the RHA, the RDRD is accountable managerially to the Regional General Manager and professionally to DRD in the Department of Health.

29. For work as a member of the regional office, the RDRD is accountable managerially to the Regional Director and professionally to the DRD in the Department of Health.

30. In all work, whether for the RHA or for the regional office, the RDRD will comply with the terms and conditions of employment for civil servants and for members of the NHS Executive in respect of matters of probity and confidentiality.

TERMS AND CONDITIONS OF SERVICE

31. The post is full time. During the transition from Regional Health Authorities to regional office working as part of the NHS Executive part-time appointments will be considered where such flexibility is in the interests of the RHA/regional office and the postholder.

32. Other terms and conditions will be set by the Regional Director.

Examination of witnesses

MR COLIN REEVES, Director of Finance and Corporate Information (formerly Regional Finance Director, NW Thames RHA; a member of the Culyer Task Force); and DR GRAHAM WINYARD, Deputy Chief Medical Officer and Director of Health Care, NHS Executive, were called in and examined.

Chairman

549. Good morning and thank you for coming. May I ask whether either of you or both of you wish to offer us an introductory comment or shall we go straight on with the questions?

(Mr Reeves) I think we can go straight on with the questions, my Lord Chairman.

550. Well, what steps has the Department of Health taken so far to implement the Culyer report?

(Mr Reeves) Thank you, my Lord Chairman. As you probably know, the Culyer report produced a timetable setting out the progress which needed to be made over the next two years, and indeed that was endorsed by the Secretary of State on 15 December 1994. The prime responsibility for implementing

Culyer lies with Professor Peckham, the Director of Research and Development, who will be reappearing before this Committee in March. However, I should say that at this stage he has indeed set up four implementation groups to implement Culyer: the first one being a project implementation team whose responsibility is for the overall oversight of the implementation; the second a service support group whose task is to determine the criteria for service support; an R&D facilities group whose criterion is to look at the R&D facilities; and the fourth group, which actually concerns myself, my Lord Chairman, is the finance working group whose task it is to consider the costing methods and criteria. Perhaps I should declare an interest here since I was Chairman of the sub-group responsible for these areas within

7 February 1995]

MR COLIN REEVES AND DR GRAHAM WINYARD

[Continued]

[Chairman contd.]

the Culyer Task Force. Basically the role which I have undertaken since Culyer was produced is to produce a costing methodology which enables us to isolate the direct and indirect costs of research, the service support costs and indeed the research facilities costs, building on the work of the preliminary guide which was published in 1993, entitled *Costing Research and Development*. I originally considered that the work could be undertaken by the National Steering Group on Costings which has been in existence for two or three years, but I felt that this was such an important piece of work that we did need to set up a specific, dedicated group, and indeed in November 1994 I asked David Pace, who is the Director of Finance for South Thames, to chair that group. Indeed his remit is to produce a costing methodology during 1995/96 to accompany the research ratings assessments which will be undertaken during 1996/97 with a view to implementing Culyer by 1 April 1997. I should say as well as producing a costing methodology, my Lord Chairman, we are also concerned about the accounting arrangements. It is important to set a contractual relationship, I believe, firstly, in terms of direct and indirect costs and, secondly, in terms of service support costs between the individual providers, the NHS trusts, and the regional commissioning units. I also think it is important to set up a contract in terms of the research facilities costs and here the contract I think will be between the NHS trusts and the NHS Executive. The ultimate intention, therefore, is to produce a manual of costing and accounting and ultimately incorporating all the R&D costings in the NHS accounts, and I am hopeful that that can be achieved by 1997-98. That is the major area of work I have been involved in. Possibly I should say there are two areas which might interest the Committee. The first one is the preparation of the levy for 1996-97 and indeed discussions within the Executive Board have already taken place in terms of that to consider the concept of the levy and also to appoint a responsible budget-holder. I can indeed announce to the Committee that Professor Peckham will have responsibility for this budget from April 1996. The final point I think that is worth making, my Lord Chairman, is the importance of the single funding stream which was endorsed by Culyer and the Secretary of State. This will operate from 1 April 1995 and I have now identified the various sources of funds which will fit within that single funding stream, and I can indeed go into detail, if required, in terms of those components.

Lord Butterfield

551. I am fascinated by the progress you have made and I congratulate you. Could I ask whether you have been getting a wide variation in research overheads between one evaluation or another, or are they fairly standard? I think your little book, though I do not know if it is little and it may be quite a large book, which you mentioned may be something upon which everyone is going to seize with great interest and read with great interest, but have you seen a very

wide variation in overheads as calculated for different research projects?

(*Mr Reeves*) Yes, at this stage I think, my Lord Chairman, it is fair to say that it would be premature to come out with any conclusions in terms of the findings we have had, and indeed some of the findings we have had in terms of the wider areas of costing in the NHS suggest indeed that there are wide variations in overheads. Whether that is applicable to research-based costings at this stage I think it would be, as I say, unfair of me to state and make a conclusive comment.

Lord Butterfield] Of course, but we are sensitive to the fact that people tend to take modes and means or whatever and sometimes people feel aggrieved and we have to be conscious of their grief.

Earl of Selborne

552. I wondered if I could refer you to the timetable published in Culyer. Have you got a copy of that, page 55?

(*Mr Reeves*) I have indeed, my Lord.

553. I think it might just be helpful to the Committee if you were to run very quickly down the checklist there and tell us what has not been done as well as what has been done. I have been able to identify, from what you have just told us, I think three of the ten priority areas. That is the levy, the costing arrangements and the single stream of funding. I think it would be helpful just to be told very briefly what has happened so far and the timetable of the other seven.

(*Mr Reeves*) Yes indeed, my Lord. The timetable covers three financial years, 1994/95 to 1996/97.

554. I was just looking at 1995/96.

(*Mr Reeves*) Indeed at this stage I can say that I have established the common service levies as I indicated before and indeed have started work on the costing and production of some standardised contracts. I think at this stage it would be wrong of me to comment on the precise work undertaken by Professor Peckham. I really do believe it is important to discuss with him the development in terms of those other seven stages which we hope to be completed during 1995/96.

Lord Perry of Walton

555. I just wondered from what you said at the beginning whether you can update the table that we got in a written submission from the Department which gave the research and research-related expenditure for 1994/95 in millions. There was another entry in that report which suggested that the regional expenditure was about another £35 million to be added on to the £437 million, but there was nothing about the expenditure on trusts. I gather from what you have said that you have now got something slightly more specific.

(*Mr Reeves*) I think at this stage, my Lord Chairman, it might be worthwhile if I concentrate on the funding streams we have identified and worked out those which at this stage it is not possible to quantify but which we would like to incorporate in

7 February 1995]

MR COLIN REEVES AND DR GRAHAM WINYARD

[Continued]

[Lord Perry of Walton *contd.*]

the R&D funding stream in the future. Effectively at this stage I have identified the national research and development funds, including the CRDC, and the information system strategy which supports the national implementation of R&D, and indeed the regional top-sliced funds under the control of the regional directors of research and development; effectively those two streams together relate to a figure of approximately £60 million. There is also the research element of SIFTR and again I think the figure quoted in the previous session was a figure of approximately £120 million. I can update in terms of additional monies being made available in terms of SIFTR for 1995/96 and the "R" element of SIFTR which is an additional £10 million. Another element of course is the non-SIFTR figure of £2 million, and finally the central funding in relation to the SHAs in terms of the interim financial regime they are currently operating under and a figure there is a figure of approximately £250 million.

Chairman

556. That is for the SHAs?

(*Mr Reeves*) That is for SHAs, my Lord Chairman. The intention will be to try and identify at a later date other funding streams. This will be the result of a lot of the costing work I have identified which needs to be undertaken and also in terms of improving the information base which we have available to ourselves: we will need to identify precisely the costs of research borne by the NHS undertaken by trusts, district health authorities, FHSAs and GPs as well as understanding the specific research work they undertake. The intention will be at later date, once we can identify those sources of funds, to add them to the single funding stream.

Earl of Selborne

557. I wonder if I could just come back to the targets, and I quite understand if you would not wish to comment on those which properly fall to Professor Peckham, but two of the priorities there, to develop the public principles of facility contracts and another one to develop standard contracts, is this an area which falls to your side of the house or are you not involved with that?

(*Mr Reeves*) Certainly at this stage, my Lord Chairman, the intention for the production of the facilities contracts would be within the remit of the R&D facilities group whose primary role is to determine the criteria for R&D facilities. Once those criteria are established, then I think possibly the responsibility will be between myself and Professor Peckham in terms of converting those criteria into useful contracts.

558. And the standard contract?

(*Mr Reeves*) And the standard contract again I think relates to the service support group and indeed the project implementation group in determining the criteria both for direct and indirect costs and also more particularly in terms of service support costs. Once those criteria are determined, it will be important for myself in conjunction with Professor

Peckham to convert those criteria into realisable contracts.

Lord Gregson

559. What you have told us about the funding stream, that does not include any charitable money, does it?

(*Mr Reeves*) No, my Lord Chairman.

560. Is it your intention to include it?

(*Mr Reeves*) I should perhaps make two points here. If it is service support costs incurred as a result of work undertaken by charities in terms of research, that indeed can be added to the funding stream when it is identified at a later date. The second point I would make is that in actual fact the current figure in terms of SIFTR, or at least the "R" element or SIFTR, which relates to the excess service costs of teaching and research, does indeed incorporate some of the service costs in respect of work undertaken by charities and indeed other non-commercial organisations, such as the research councils, which is a good example.

Chairman

561. Yes, with the implication of course that any work carried out in the Health Service on behalf of commercial organisations must carry full overheads.

(*Mr Reeves*) That is absolutely correct, my Lord Chairman.

562. Now, having said that, is the question of the appropriate split between teaching and research within SIFTR still open, or has it been decided to split it 75:25, and is that because it is the right ratio or only because this has been the working assumption up until now?

(*Mr Reeves*) I think it is very much the latter, my Lord Chairman. The 75:25 is an interim working assumption, as you quite rightly state. It forms the basis of a guide to regions until Culyer is fully implemented in 1997/98. Indeed regions at this stage are not formally required to differentiate teaching from research in their SIFTR contracts, though I should say at this stage that regions are becoming more sophisticated in terms of the distinction they make between teaching and research as embodied in their own individual regional SIFTR contracts. It is fair to say again in terms of the 75:25 assumption, that is consistent, I think, with widespread current assumptions and a lot of analyses taken by a number of institutions. I would refer, my Lord Chairman, to several universities and medical schools, such as Oxford, Cambridge, Liverpool, Nottingham, Newcastle, Aberdeen and Edinburgh, all of whom as a result of their independent researches have adopted a similar 75:25 split. The same percentage was used in terms of the University of London strategy on SIFTR in 1991, and indeed the Welsh Office working party on SIFTR has also recommended the same 75:25 split. But I should re-emphasise at this stage, my Lord Chairman, that this is purely an interim working assumption and will be replaced once the implementation of Culyer fully takes over in terms of 1 April 1997.

7 February 1995]

MR COLIN REEVES AND DR GRAHAM WINYARD

[Continued]

[Chairman *contd.*]

563. There is one other important implication of what you have said, and that is that if you look at the single funding stream, as defined in the Culyer Report, there seems to be a suggestion from what you have said relating to the establishment of at least two implementation groups that perhaps that single funding stream for the R&D component may itself be split in two, one component relating to R&D in terms of health services research and the other relating to the service support for curiosity-driven biomedical research. Is this part of the Government's thinking at the present time?

(*Mr Reeves*) Perhaps you could repeat the question there, my Lord Chairman.

564. Culyer has suggested a single stream for the "R" funding. The fact that you have two implementation groups, one looking at R&D and health services research, and the other looking at service support for research, rather implies that you may be thinking of dividing that single stream into two, one for health services research (the R&D component), and the other for service support in the NHS of biomedical curiosity-driven research.

(*Mr Reeves*) I think it is fair to say at this stage, my Lord Chairman, that the single funding stream is a very supply-driven approach. It is based on identifying the various funding streams, which I have already identified to the Committee. The intention of Culyer is to move away from this supply-led approach to a demand-led approach by identifying those three components of costs that I referred to, the direct and indirect costs, service support costs and research facilities costs. By 1 April 1997 we do believe that we will have this demand-led approach in position in which case the demand-led single funding stream which incorporates those three elements will take over from the currently identified research streams included in SIFTR, and SHA funding. What I should also say is that in terms of pre-protocol and curiosity-driven research, that is something which again Culyer very much endorsed. It could well be that individual trusts, with the acquiescence and agreement of the DHAs who contract with them, would wish to see this type of research funded, but that would be a local agreement at this stage between the trusts and their respective purchasers.

Lord Butterfield] You will be putting into your diary for future consideration the division of the NHS activities into their three new businesses because it does seem to me, and I am sure to all members of the Committee, that it is going to be very important that as we go on dividing things up, we do not get more and more rigid and that we have flexibility in and out.

565. Do you consider the system for service support proposed by Culyer is compatible with the Secretary of State's duty, under section 51 of the National Health Service Act 1977, "to make available, in premises provided by him by virtue of this Act, such facilities as he considers are reasonably required by any university which has a medical or dental school, in connection with clinical teaching and with research connected with clinical medicine or, as the case may be, clinical dentistry"?

(*Mr Reeves*) Perhaps I should make one technical point at the start, my Lord Chairman, and that is that

section 51 of the NHS Act 1977 which you referred to is indeed being amended by the 1995 Bill to make this duty apply explicitly in trusts which of course did not exist when the 1977 Act was enacted. With that technical aside, I would suggest that I do believe that a single explicit funding stream for research will provide a framework for ensuring that facilities are maintained in connection with clinical research both at medical and indeed at dental schools, so I do believe that the system for service support and indeed research facilities as proposed by Culyer is indeed compatible with the Secretary of State's duties. However, having said that, I think it is important to put this in context with what is going on in terms of the concept of the levy and how that applies in terms of the NHS. As I said before, Culyer does propose a demand-led approach using quantitative research assessments allied with better costing information, and in this context the levy is extremely important in determining and ensuring that the demand and supply are in balance and, therefore, prevent any cross-subsidisation with service contracts. I think that is extremely important, otherwise if demand and supply are out of balance, it could well be that there is, in terms of the individual trusts involved, an increase in prices which could have a deleterious effect in terms of reduced potential income. The trust, in responding in terms of trying to balance its books, will have to reduce its expenditure and it is possible in that respect that some element of that expenditure might indeed relate to research and development. So the first important point, I think, my Lord Chairman, is to ensure that the levy is flexible enough to ensure that we do balance demand and supply for research. I think I should also make a point that we do need to take account of change within the NHS and I think it is important that the system is not ossified. We have seen various changes and we will continue to see them occurring, such as the movement away from acute to primary and community care, to more emphasis on out-patient and day-care as opposed to in-patients. In terms of the future mode of care, I would exemplify the expert study on cancer services report, stating that the growth is being concentrated on DGH facilities rather than teaching hospitals. All of this gives an indication, I think, that whilst I still believe the Secretary of State's endorsement and her duties are entirely fulfilled, we have to consider this in terms of individual hospitals and other processes of change. The final point I would like to make is also that at this stage it is important that the CRDC in particular, assisted by the National Forum, focus on establishing the priorities within research and development because at the end of the day NHS resources are indeed finite, they are not unlimited, and indeed research will have to compete with other priorities and contending NHS services. So whilst I am happy to confirm the Secretary of State's duties will be fulfilled in terms of the section of the Act which you referred to, I would flag up the importance of having a flexible levy system. I would also indicate the importance of sensible prioritisation being undertaken in terms of research *vis-à-vis* other competing NHS services, and, thirdly, would ask the Committee to take account of the fact that we are in a changing world and the mode of care will change

7 February 1995]

MR COLIN REEVES AND DR GRAHAM WINYARD

[Continued]

[Chairman *contd.*]

and some of the institutions in relation to that mode of care will also be affected.

Lord Gregson

566. You mentioned in that answer that changes which have taken place in the National Health Service will have some effect and so forth. Could you explain a little bit further? I have been involved with a situation in a certain hospital which in fact has a loose relationship with the university; it is a teaching hospital. Now, that has existed since the 19th Century almost from that point of view and it has been a cosy relationship and it has worked extremely well. Now that the hospital is a trust, it is almost ring-fenced to a large extent so any spending which takes place on the premises for clinical treatment related to research must be entirely devoted to the trust, otherwise the trust cannot work in effect, legally cannot work, so that relationship is now being made a ring-fenced relationship and there is a barrier between them almost. Is that not the sort of situation which will develop, do you think? There is no way the university can say, "Well, those premises in that hospital trust are under our control" because no chairman of a trust in his right mind would allow that to happen.

(*Mr Reeves*) What I would say, my Lord Chairman, in terms of contractual relationships which I think Lord Gregson has referred to is that it is important that the accountability lies with the trust if it is contracting with a purchaser or, in the case of research and development in the future, with a national or regional commissioning unit, and I think that is important.

567. Or with a hospital-to-hospital transfer?

(*Mr Reeves*) That is correct, but at this stage I would not indicate to the Committee that I believe that the relationship, which has existed extremely well before between medical schools and individual trusts, would be undermined by the implementation of Culyer. I do believe that strong financial relationships still exist and will exist in the future between medical schools and the trusts and I certainly, as indeed does the NHS Executive, have no wish to undermine those relationships.

Lord Gregson] But that relationship has got to change now that the trusts have been established. They cannot leave it to run on an all-pals basis any more.

Chairman

568. And under the Health Authorities Bill now under consideration, with the disappearance of the regions in their present form, what will be the position of university representation on teaching hospital trusts, which was part of the previous arrangement?

(*Dr Winyard*) If I may answer that, my Lord Chairman, that will continue. We are committed to safeguarding, and I hope improving, that partnership. I would suggest that what is happening in one respect may be more difficult, but I would argue, on the other hand, what is better is that

arrangements are having to be more explicit and I think the word "cosy" was used—

Lord Gregson] It is more than explicit; they have got to be legally-based which is quite different.

569. That representation is not on the face of the Health Authorities Bill. We have had an assurance from Ministers that the universities' representation will be protected, but it is not on the face of the Bill.

(*Dr Winyard*) No, I know that, my Lord Chairman. I am pretty certain that there is no explicit representation of any particular group on the face of the Bill, but very firm assurances have been given.

Lord Gregson] The trusts themselves have got to be extremely careful that they follow the legal path absolutely, otherwise they are in trouble. Once you have created that situation by creating the trusts, then you have got to separate the two and you have got to have a new relationship which I have not seen described anywhere.

570. Well, we look forward to hearing more on that because it is crucially important to the future of research in the NHS, as I am sure you are both well aware. The SGUMDER econometric study of SIFTR. Has that study been concluded and what was its outcome?

(*Mr Reeves*) Indeed it has been concluded, my Lord Chairman, and indeed an announcement was made on 22 November 1994 during the health day debate and confirmed in FDL/94-71. What that FDL suggested was that as a result of the multivariate analysis undertaken, it was important, in the view of the Secretary of State, to allocate an additional £40 million to protect the combined teaching and research activity through an increase in the SIFTR allocation.

571. That was not new money. That was money that was derived from the existing SIFTR budget and therefore had to be removed from NHS funding for hospitals and trusts, was it not?

(*Mr Reeves*) I think the intention was to provide more protection within existing resources for the NHS costs of teaching and research while we made better arrangements for research across the NHS. The arrangement you have indicated, my Lord Chairman, is absolutely correct. We felt at the time that it was very important, firstly, to recognise the high spending associated with both teaching and research compared with the current SIFTR allocation as indicated by the multivariate analysis and, secondly, the chance as a result of the funding arrangements you have mentioned to enable providers to reduce their prices. As your Lordship states, this was matched by a reduction in the purchasing power of the referring DHAs. The net effect has to enable providers, by reducing costs, to become more competitive with the possibility of increasing additional referrals in the future either from those DHAs currently referring or indeed the DHAs who have previously not referred to those teaching hospitals. I think the second major benefit of the approach we adopted was to improve the capitation position of the referring DHAs which means that in terms of additional growth monies in future, they would be a greater recipient of those growth monies than they have been historically. So

7 February 1995]

MR COLIN REEVES AND DR GRAHAM WINYARD

[Continued]

[Chairman *contd.*]

we did feel that those two advantages, one for the provider and one for the DHA, were both advantageous in terms of recognising the importance of R&D within the NHS.

Lord Perry of Walton

572. The medical and dental schools have given us a lot of evidence and there is indeed a real worry that the expansion of research into general practice and National Health Service care is going to prejudice the amount of money that goes into biomedical research in the medical schools. Your comment this morning worried me still further about amending the Act, and despite your assurances, it will cause worry until the amendment is clearly understood. The initial idea that this Committee in its previous report put forward, which resulted in Peckham being set up, envisaged almost a separate research council, in other words, provision of a separate funding stream for NHS research from that which supported the MRC and so on. The fact that that has changed to a single funding stream is another cause of the worry of the medical and dental schools. Can you offer any reassurances at all that that worry is not justified because the worry is very real and is damaging, I believe at the moment, many of the departments that are active in research?

(*Mr Reeves*) I would like to give an assurance, my Lord Chairman, that certainly the medical and dental schools should be confident that the implementation of Culyer will be of benefit to them, particularly those involved in substantial research. As I indicated before, the whole intention of Culyer is to move to a demand-led approach which will identify good research and will respond to it in terms of funding. I think that is the important point. However, I would also point out, I think, in terms of the previous reply that we do have to consider that research and development is one element of the NHS and we need to ensure that there is proper prioritisation of the research and development demands against other competing NHS services. I think that is an important point to take account of. The second point I would make is that again we are in a changing world, a dynamic world in terms of particularly the NHS, and I have to say again that the position of individual medical and dental schools or at least the trusts in relation to those medical and dental schools needs to take account of the changing world. I use the example of cancer services where the focus in future will be on the developments within DGHs as opposed to teaching hospitals, and it is important in this changing world that both individual university hospitals and indeed the medical and dental schools take account of those changes.

Chairman

573. Will there not be a danger though that the need to remove that levy from the present funding stream in the NHS will have the effect of impairing certain clinical services and will you not anticipate some resistance on the part of independent trusts to

having that levy removed from their present funding in order to support research?

(*Mr Reeves*) I am not sure I understand your comment, my Lord Chairman, in terms of the change in the levy.

574. Well, it has been suggested to us that the funding at present of many hospital trusts and the remaining district health authority-funded hospitals includes SIFTR money which at present is providing clinical services for patients and that when the levy is imposed with a top-slicing of those funds, some of them are likely to resist having that funding removed in order to implement the Culyer proposals for the support of research.

(*Mr Reeves*) I understand your question, my Lord Chairman. The whole intention of the levy is to allocate the monies available to the NHS directly to the DHAs and then, as a result of discussion between the DHAs and the NHS Executive and the budget-holder responsible for the particular levy decide on the overall size of that levy. In the case of research and development we are talking about Professor Peckham as budget holder. I think the important thing is to have constructive discussions with purchasers to ensure that they are happy to accept the logic of a levy. I know the name "levy", by its very nature, suggests something taking a mandatory form and whilst that is indeed the case, the decision about the quantitative size of a levy is important to be decided upon only after extensive discussions with the purchasers involved. They need to be content that the amount of money taken away from their individual DHA allocations is justifiable, and indeed that is the important part of the consultation we are doing on all the levies which we hope to implement in 1996/97, the levy for teaching, and the levy for research and development being just two examples of that type of approach.

Chairman] They would of course be much happier with new money, would they not?

Lord Gregson

575. Cancer is probably, is it not, the most intense field of research and certainly the most intense field of charitable-supported research within the National Health Service? Certainly having regard to the charitable donations for cancer treatment through the Imperial Cancer Research Fund, etcetera, it is the highest of all of the disease-specific medical charities in effect. Can you explain why there is a change of emphasis taking place away from the teaching centres or the centres of excellence to spread it more widely?

(*Dr Winyard*) Could I respond to that, my Lord Chairman? You are familiar, I imagine, with the report produced by the Committee chaired by the Chief Medical Officer.

576. Yes, I am.

(*Dr Winyard*) That is what will drive this pattern of changes which is, I think, basically about taking the results of studies of the best patterns of cancer care and making sure they are systematically applied across the NHS which will inevitably produce changes in the patterns of service.

7 February 1995]

MR COLIN REEVES AND DR GRAHAM WINYARD

[Continued]

[Lord Gregson *contd.*]

577. But surely that is putting the cart before the horse. You need to provide the service first before you start changing anything. Say, a patient has got to go to the local cottage hospital for lung cancer, unless that is aligned with a very wide back-up service, that is a nonsense, is it not, surely?

(*Dr Winyard*) Yes, but—

578. I exaggerate by saying the local cottage hospital, but the Chief Medical Officer's report said in effect that we want more widespread expert treatment for cancer.

(*Dr Winyard*) Yes.

579. But you have got to create the expert treatment for cancer before you can start shifting patients there and all of us realise that you are taking those patients away from a research-centred situation.

(*Dr Winyard*) In some cases, yes, and in some cases one would see more patients going to the specialist centres. For each particular sort of cancer we will want to see a pattern of service that will produce the best outcomes. What the Chief Medical Officer was saying, and his Committee, was that at the moment we do not always have that. We have the care of some cancers divided over too many centres and in other cases with insufficient referral to the very specialist centres which are the places which get the best results.

Lord Gregson] I still do not understand it, but thank you.

Baroness McFarlane of Llandaff

580. I think the Committee are interested in knowing to whom the research facilities funding will be paid—the deans of medical schools or the managers of the teaching hospitals?

(*Mr Reeves*) I think, my Lord Chairman, that I stressed before the importance of the purchaser in determining contracts in the future in terms of research and development and effectively the answer to the question will depend on who the purchaser is and what the purchaser wants in terms of research and development. Certainly if a purchaser were to contract with the medical school, then my belief is that the accountability would lie with the dean of the medical school and, conversely, if the contract were with an NHS trust, the accountability would lie with the chief executive of the trust. Really it depends again, and I stress the importance, on the purchaser in determining precisely what he wants and where he wants the research and development to take place, and that will determine the accountability and indeed will determine the actual payment made to particular organisations.

Lord Gregson

581. Surely the auditor-general will determine this, will he not? It is not up to you to determine it.

(*Mr Reeves*) No, the internal market, I believe, my Lord Chairman, will determine it. I think it will be at the discretion of the purchasers to determine where they wish to contract, whether it is with the NHS providers, the NHS trusts, or with other organisations, such as the medical schools, and there

will be complete freedom in terms of the purchasers determining whom they wish to contract with as long as they undertake a basic statutory and legal obligation as reflected in the NHS Act.

Lord Gregson] I am sure the Public Accounts Committee in another place will have something to say about that.

Chairman

582. Is there not a serious danger though that this may lead to creating too wide a variety of funding streams for research? Would it not be more sensible to consider having a mechanism whereby regional directors of research and development, in collaboration with the deans of the medical schools in each area, might develop a kind of mechanism which would oversee the distribution of such funds?

(*Mr Reeves*) I do believe, my Lord Chairman, that the intention of Culyer is to ensure that advice and consultation undertaken with a wide variety of sources would now indicate the newly formed CRDC taking account of a variety of purchaser/provider interests and again supported by the National Forum which again embraces a number of individual and varied interests. The importance of the framework proposed by Culyer is that, on the advice of the CRDC, supported by the National Forum, we will indicate through the regions or the regional offices, as they will be called in the future, the terms of the individual regional research and development programmes given the support they are given by the regional commissioning units. So I do believe that it is impossible for me at this stage, my Lord Chairman, to make a categorical answer, but I do believe that Culyer sets up a framework to ensure that sensible decisions are made, taking account of the varied interests of all parties.

Lord Butterfield] Will the regional directors of research have information about where the money is going? I had an experience when I was running the Cambridge faculty when a SIFTR grant came that it was all put into nursing and this was because it was felt that having plenty of nurses standing in outpatients would ensure that the local population was not embarrassed by the presence of medical students. I never heard about that and in fact I could have done a deal with the matron to have used that money a little more wisely for teaching, but it does seem to me very important that the regional directors of research know where the money is going so that they can alert the deans and themselves to the pattern of expenditure which is possible.

583. What has happened to your Advisory Group about the teaching component of SIFTR?

(*Dr Winyard*) This is the last piece of the jigsaw, I hope, that we are putting together. The Advisory Group is going well. I understand that your Lordships have the revised membership list and the terms of reference, I hope. We have had our first meeting and we have got two more, one next week and another in March, and we are committed to reporting to Ministers by the end of March and that is the timetable. I am feeling pretty optimistic that we will be able to stick to that because the group came together extremely well at its first meeting. I could

7 February 1995]

MR COLIN REEVES AND DR GRAHAM WINYARD

[Continued]

[Chairman *contd.*]

run through the broad issues we are trying to cover, if that would be helpful, and I would be extremely interested in any views or steer which your Lordships would like to give us. We are very much at the thinking stage.

584. I think it might be helpful, if you let us have something in writing about the principles underlying the investigation that you are conducting.

(*Dr Winyard*) I would be very happy to do that.

585. One thing which is, I think, of importance is the future of dental SIFTR and the funding of dental hospitals?

(*Dr Winyard*) Yes, that is a slightly separate issue and it is not part of the remit of my specific group, but, as you may know, it was SGUMDER who first alerted us to the fact that there did appear to be problems which I think basically stemmed from the fact that dental hospitals are rather different entities than ordinary teaching hospitals, if one can call any teaching hospital "ordinary". These concerns led to a sub-group being set up to look at dental SIFTR whose recommendations have been accepted by Ministers, the main one being that instead of the historic approach which was a proportion of overall costs being funded through SIFTR with the hospital having to seek the balance, whatever that may be, through contracts, the recommendation is that there should be full funding, 100 per cent funding, of the dental out-patient work required for teaching the GDC curriculum. Virtually all of that work, as you know, would, in other parts of the country where there is not a teaching hospital, be carried out by dental primary care practitioners. So the recommendation is that the full 100 per cent of whatever dental out-patient work is necessary to sustain teaching be met from SIFTR and the other dental hospital costs, that is non-primary dental out-patient services, would be funded through the internal market mechanisms, the costs through purchasers, and we have a group due to report by the end of this financial year looking at how those recommendations could be put into effect.

586. And that is fine so far as the teaching of dental students is concerned, but what about research?

(*Dr Winyard*) Research will come in as part of the Culyer proposals.

587. Anxieties have been expressed to us about the future of academic medicine. First, one of the great developments of the last ten, 15 or perhaps 20 years has been the fact that the NHS has been prepared to fund the establishment of chairs in clinical disciplines in medicine in order to develop teaching and research in a variety of specialties where the universities did not have the funds to provide those appointments. What is going to happen to this process when the regions disappear? We are also concerned about evidence of managerial pressure even upon clinical academics with honorary consultant contracts asking them to increase their clinical work-rate to the detriment of their ability to engage in research.

(*Mr Reeves*) That is absolutely right, my Lord Chairman, and indeed I think Professor Peckham mentioned it in when he spoke to this Committee in November. A questionnaire was sent to the regions in August 1994 and the responses have now been

obtained by the NHS Executive which suggest that indeed we are funding 577 whole-time equivalent posts valued at £21 million. I would like to give an assurance at this stage, and this was discussed with the regional directors of finance at their meeting in January 1995, and indeed will be discussed by the NHS Executive Board in February, this month, that the basic principle that we would like to establish is the intention to honour those commitments which currently total a figure of £21 million. This is because the NHS Executive values very highly the work done and the collaboration required and needed and achieved in the past with the universities. We have given some consideration as well to the mechanism and whereas we believe that much of the funding could be devolved to local level, and indeed would be as the result of an agreement reached between individual trusts and their DHA purchasers, this would be primarily in respect of those areas which relate to local service provision. But we do believe that certain academic posts relate to areas which have a supra-district or even a national impact, and indeed I think teaching and research and development fits within that criterion, so at this stage our recommendation to the NHS Executive Board would be again that all districts should contribute to the levies for teaching and research from 1 April 1996 in respect of those academic posts.

588. And for the future, how will any mechanism be established which will enable future academic posts to be created which in the past have come from regional funds?

(*Dr Winyard*) I think one important point is that they have not all come from regional funds. We are aware that both in the past and at present district health authorities are making substantial investments. I think in the future the investment might come from either of the two levies and that would be for work appropriate to a national basis for teaching and research, but also from purchasers getting together and acknowledging, as many have already done, that some service needs are best tackled through investment in academic departments and agreeing locally to provide them.

589. Do you wish to make any comments upon the potential detrimental effect, as some see it, of the Calman report on the duration of postgraduate training in medicine relating to training for academic careers and what are your views relating to the future of the distinction awards system and locally-negotiated pay?

(*Dr Winyard*) I wonder if I could get the latter two points out of the way first because there my hands are very much tied, as I am sure your Lordships are aware. The distinction awards system, its future, and locally-related pay are now very much intermeshed in talks taking place between officials and the BMA and we have the Doctors and Dentists Review Body report coming out shortly and until we know their recommendations and the outcome of those talks and Ministers have had a chance to consider that, I do not think it is possible for me to say anything terribly sensible.

590. Which is rather what we expected you to say.

7 February 1995]

MR COLIN REEVES AND DR GRAHAM WINYARD

[Continued]

[Chairman *contd.*]

(Dr Winyard) Yes, I am sorry. On Calman, and this is one of my responsibilities, the implementation of Calman, I am obviously aware of the concerns and they are being addressed in a working party being chaired by the Chief Medical Officer into the implications of the main report for academic and research medicine and we hope to finalise the report at a meeting next week. I think it is fair to say that this has always been a problem because clinical academics are training for two careers and it would be perhaps even perverse to say in a new system that is seeking to define in a much more coherent way than has ever been done before the training necessary to achieve specialist status, one could not really say that could be cut down on for one group of doctors who will have full clinical responsibility for patients. Most of the colleges are recognising up to one year of research and, that year need not include clinical work, as part of the programme leading to the CCST, but I think more importantly the approach that we will be taking to workforce planning will be a much more flexible one and there will not be difficulties about quotas so that when people want to diverge from the higher specialist training programme to do a longer period in a research post, they will be able to do that and come back in without detriment and without having to jump through bureaucratic hoops.

591. It has been suggested to us that the transfer of some of the money saved on a reduced number of training posts into support of posts in academic units, perhaps NHS research training fellowships, for example, might be a sensible means of moderating the effect of this change. What would you think about that suggestion?

(Dr Winyard) I understand why it has been made. I am not sure how practical it is going to be. We are obviously looking overall at the way money may recycle, assuming there are significant reductions in training posts. Now, in many specialties, that is unlikely to be the case for several years because the immediate requirement of Calman is obviously the need for even more consultants than the current rate of expansion.

Lord Butterfield] If we are going to have a knowledge-based Health Service which we all want, I am concerned that we ensure that the people who have the IQ to keep up with the most modern intellectual developments at the forefront of medicine are not embarrassed into being pushed into other forms of activity, and I am sure you are too, and I think, therefore, it is terribly important, whenever we can, to make it clear to the bright people who can understand the complexities of the modern problems especially the managerial class, that we respect their ability. Otherwise, we are going to risk a gradual run-down in the quality of the people who understand what is in the literature. I am concerned that we do not get into a situation where the clinicians whom I greatly admire and respect are able to say, "You are not worth your pay because you are not doing as many patients as I am doing" because that is a quick way to start the slippery slope to a second-class Health Service. If it is going to be knowledge-based, then we have got a responsibility

because the research people are the very people who are going to maintain that knowledge base.

592. I think it is something that we would all endorse.

(Dr Winyard) And it is something that we are absolutely committed to.

593. The supra-regional services advisory group in the past has had a major responsibility for exploring new methods of diagnosis and treatment on a supra-regional basis and I understand that the Department is expecting that that particular group may in future look at the outcomes and implementation of some of their processes. What is the source of funding for that group and is it a charge on the R&D budget of the NHS and is it likely to be a future charge on SIFTR?

(Dr Winyard) I think it would be probably best if we responded in writing. My fairly certain understanding is that it is a separate levy as part of the common services levy, so it will be a levy on all purchasers.

594. It comes out of central funds and is not likely to be part of the R component?

(Mr Reeves) Yes, the intention, and indeed this has been discussed quite recently just before Christmas with the NHS Executive Board, would be the supra-regional services would form part of what we call the common services levy, and that is a different levy from the intended introduction of the teaching levy and the research and development levy from 1 April 1996.

595. We have recently had sight of a contract drawn up between the Secretary of State and a major hospital trust with a fine record of research. One of the requirements in that contract suggests notification before dissemination, proposing that the results of the research undertaken should not be published before being checked with the Secretary of State. Is this likely to be a continuing requirement? It is not one that I have been familiar with as being imposed in the past.

(Dr Winyard) I think it would probably be safest if we responded in writing to that question.

596. Yes, that would be a matter of some concern to us as it seems to suggest that the Department might have an embargo on the publication of the results of research. I may have misinterpreted that, but I would very much like to have it clarified.

(Dr Winyard) I think we will have to.

Baroness McFarlane of Llandaff] I think it has been a condition in the contracts in most nursing research contracted by the Department.

Lord Gregson] I think it has been so in most bodies outside doing research, that he who pays the piper calls the tune.

597. Are there any other points that you would like to raise at this stage?

(Mr Reeves) Thank you very much, my Lord Chairman. It has been a welcome opportunity for myself and Dr Winyard to discuss the implementation of research and development in this Committee.

7 February 1995]

[Continued

Memorandum by Dr Malcolm Green, Director, British Postgraduate Medical Federation**I THE R&D PROGRAMME****1. *The need for research in the NHS***

The NHS R&D initiative stemmed directly from the House of Lords report on the arrangements for research in the NHS. The commitment of Government to implement this report, and the creation of the R&D Directorate are great successes. These have been founded on the explicit and implicit belief that research is not only desirable but indeed essential for the NHS, as well as for medicine more generally. However it is vital that this strategic objective continues to be highlighted, and the justification stated. Although those of us committed to research in the NHS believe in its value in the short and long term, there continue to be some who question this. Such doubts were expressed at the start of the Culyer Task Force's discussions. They have been more recently highlighted by John James, one of the members of the Task Force⁽¹⁾, and refuted⁽²⁾.

I remain committed to the value of research in and for the NHS, and have expressed some of the reasons for this generally, and clinical research specifically, in the enclosed BMJ article⁽³⁾.

2. *A knowledge-based health service*

The greatest single achievement of the NHS R&D strategy has been to create within the NHS a belief in, and a strategy for, a knowledge-based health service. This phrase appears deceptively simple, and obvious. Some might argue that health delivery has always been knowledge based, and that this requires no shift in perspective. However, the implications of accepting a knowledge based health service are substantial. It implies that NHS and clinical services and strategies should always be based on best available knowledge. This has to be rigorously derived, appropriately analysed, and disseminated. Even more difficult, it has to be widely implemented throughout the service. At present these criteria are frequently not fulfilled. Widespread commitment to them requires major changes.

I am delighted that the concept of a knowledge-based health service put forward by the Director of R&D and supported by his Directorate and the CRDC has been accepted by the Secretary of State, Ministers, and the NHS Executive. It is essential that this commitment continues through changes in Ministers and senior NHS Executives. It needs to become a core part of the NHS culture at every level. It is one of the yardsticks against which strategy and practice in the NHS should be judged.

3. *Achievements of the R&D strategy*

Michael Peckham has been in post as Director of R&D for only four years. The achievements in this time have been substantial. Nevertheless there are those who are critical, and who have questioned its achievements: e.g. Grahame-Smith⁽⁴⁾. I cannot subscribe to his views. Since there was no cohesive R&D strategy in the NHS before 1991, the task was immense. It was necessary to set up an R&D team within the DH/ME. This was followed by review of the current status of research projects within the NHS. There has been major progress in focusing on new priorities and creating the concept of a strategic approach. The disparate units supported by the DH have been rationalised, and the Cochrane and York Centres set up. The Culyer Report itself grew out of the need for an analysis of the way forwards, and could not have taken place without the R&D strategy firmly in place.

4. *The NHS R&D strategy*

The strategy for a knowledge-based health service has several elements:

- (a) The appropriate procurement of NHS research, and support for research carried out in the NHS, both short and long term.

This has been addressed by the Culyer Report, which proposes a framework.

- (b) The evaluation of research, nationally and internationally.

The Cochrane Centre will play a pivotal part in this. It is essential however that this process be encouraged elsewhere, by knowledgeable and unbiased specialists.

- (c) Dissemination of the results of (a) and (b) above.

The dissemination needs to be in a form which is authoritative and easily handled. There are some mechanisms for this already, but they need to be greatly strengthened. The York Centre will play a great part in this, but again the process must have wide ownership.

- (d) Implementation

Translation of (a), (b) and (c) into the final common path, namely effective implementation within the NHS is the most vital, and perhaps most difficult step. This will require widespread commitment to a range of mechanisms including guidelines, agreements as to Best Practice (or Appropriate

*7 February 1995]**[Continued]*

Practice), Continuing Medical Education, Audit etc. Many of these are developing but need to be integrated into the overall knowledge-based health service. This area is one where great progress could and should be made in the next five years. There may need to be research into how to change behaviour in health professionals.

5. Areas of weakness in the R&D programme

It has not been possible to achieve all aspects of a knowledge-based health service within four years. Whilst the framework is in place, it needs to be built upon and strengthened progressively. Perhaps the greatest area of weakness is in communication of the aspirations of a knowledge based health service to those in the field. I would advocate that the next phases should be accompanied by structured communication strategies, outlined below: para. 6.

6. R&D Communication Strategy

There are two aspects to R&D communications:

- (i) Communicating the thinking, aspirations and achievements of the NHS R&D strategy and Directorate: this would in the future include also communicating the thinking and advice coming from the National Forum and the CRDC.
- (ii) Communicating the results of the research itself: the output of the Cochrane and York centres, and others, to provide the basis of the knowledge-based health service.

Both of these require major communications strategies but can be viewed separately. The first is the task of the R&D Directorate itself, and I believe should be given more priority over the next year or two.

The second is a much larger task, and is part of the ongoing commitment to a knowledge based health service. This will need considerable commitment, thought and resources, over the long term.

Communication is an area which has been relatively underdeveloped in the NHS, and certainly under-resourced. There is, however, increasing recognition of its importance in business, and this is flowing through into the NHS. The Audit Commission report on communication between hospitals and patients in 1993 concluded that it was vital to put time and energy into this activity, and that it was appropriate for resources to be devoted to communication strategy and process⁽⁵⁾.

7. Developments

There are difficulties in funding the service costs of evaluating expensive new treatments. A current example is the cost of evaluating small bowel transplantation. These costs can be very high and are not covered by the R&D budget. Currently the clinical costs of such therapies if uncommon, expensive and of proven worth can be covered by the Supra Regional Services, and funded on advice from the Supra Regional Services Advisory Group (SRSAG). However, evaluation to show that they are effective cannot be funded by the SRSAG.

It is now proposed by the Department of Health that the Supra Regional Funding mechanism be extended to cover the service costs of evaluation of such developments.

This seems a sensible way forwards, and I support it, provided the evaluations are subject to rigorous review and are commissioned in conjunction with the R&D Directorate. It is also important that the SRSAG continues to have adequate medical representation.

II. THE CULYER REPORT

1. Recommendations of the Task Force

As a member of the Task Force, I sign up fully to the report. Indeed I welcomed the setting up of the Task Force and the opportunity to contribute to it. I outlined my belief in the need for such an approach in my BMJ article of December 1992, and although this has now been overtaken by events, I hold to the general views expressed in it.

2. Single Funding Stream

I support the principle of a single funding stream. It allows clear identification of funds to support the service costs of research, which were in danger of being driven out by the service market. It achieves transparency and accountability. There are however, potential dangers, which include:

- (i) That the money will be topsliced by the Treasury, NHS Executive and others down the line. There is of course the alternative possibility that understanding of the need for R&D and the value of a knowledge based health service will cause the funding stream to be increased rather than decreased.

7 February 1995]

[Continued

The Secretary of State has indeed indicated that she wishes to see this happen, and it is important to continue pressure for this commitment to be carried through in the short and long term.

- (ii) It is appropriate that identified individuals (National and Regional Directors of R&D) have accountability for the funding stream, but this raises another danger. It is that the strategy and allocations of the funds will be unduly influenced by the perspectives (or even prejudices) of a very small number of people. This leads me to two conclusions.
 - (a) That the national and regional Directors of R&D should be of the highest possible quality, and should have breadth and depth of experience in research, and research strategy as well as clinical medicine. Fortunately the present holders of these posts are indeed of very high quality, but it is important that there are secure mechanisms for ensuring that this is maintained in the future. There needs to be appropriate representation of key stakeholders including the universities, MRC and medical charities, as well as the NHS on search and appointments committees for these posts.
 - (b) There should be some checks and balances in the powers of the core team. There will be input from the CRDC and the Forum, and it may be that there should be formalised mechanisms by which one or other or both of these can express its views to Ministers directly if necessary, as a fail-safe mechanism.

3. *Explicit funding*

The new funding stream will be explicit, which again has advantages and disadvantages. One of the greatest advantages is that within provider units, it will be possible to identify money which flows down to support research and its service costs. This will powerfully focus the minds of managers, health professionals and scientists on the need for priority to be given to this activity and of its value to the organisation. This is an important shift already evidenced within the ex-SHAs. It should give more power to clinical researchers within the service framework. One disadvantage is that service purchasers (FHSAs and GPs) will identify their subvention for R&D and may collectively question it and/or seek to diminish it. The research community will need to continuously make clear the added value of this activity for the short and long term health of the NHS and its patients.

4. *Research Contracts*

4.1 "Packaged Contracts"

Where a provider has a large research portfolio, with projects, programmes and facilities, I would like to see the R&D support rolled up into one contract (paras 3.47, 3.48 and 5). This broad brush approach is analogous to HEFCE research funding, which is based on units of assessment, quality and quantity, but is then delivered as a single lump sum to the institution. HEFCE "R" funds are not earmarked, nor linked to specific departments, individuals or research programmes. A similar approach could be adopted in the NHS. This minimises bureaucracy. It also has the merits that the institution can decide on its priorities for spending the funds within its overall research portfolio (or even outwith it) and can invest in new ventures and strategic growth areas.

Such "rolled up" contracts should avoid the need for providers to bid specifically for service support funds for small or medium sized new projects in the intervals between assessments (para 3.85).

4.2 Facilities funding

I see this as a vital part of the programme, particularly to start with ie for at least 10 years! There may be temptation to move rapidly towards infrastructure costs being tightly linked to projects and programmes. On the contrary, I believe such a move should be made slowly, if at all. It is vital not to destabilise institutions, and to give them a chance to prove their research strategies, as well as to adjust their activities and the mechanisms for funding them. Furthermore research needs stability. It does not thrive in an overly competitive and uncertain environment. Accountability must be matched with a reasonable degree of security and long-termism.

4.3 The Research Contract (3.80-3.83)

Contracts within the NHS are, or should be, statements of agreed practice (and funding) rather than formalised legal documents. The same is true of the letters of agreement by which research charities and others fund research projects. It is vital that the purchasers (NHSE R&D) and the providers do not get bogged down in legalistic detail. The research contracts proposed by DH for the ex-SHAs were of this type, over specific and legalistic. The documents finally agreed are somewhat better, but not ideal.

7 February 1995]

[Continued

The current contract between the DH and the former SHAs (exemplified by that with GOS) is attached ⁽⁶⁾. I have several comments:

- (i) The review process is inappropriately onerous. It is reasonable to have Thompson-type reviews at periodic intervals. The level of detail called for on an annual basis is onerous, and will be very difficult for DH to analyse or judge. I recommend a considerably abridged review, if any, annually, with perhaps a slightly more structured review once between each national review exercise. This is in line with HEFCE practice for research funding to universities.
- (ii) The requirement for notification of communications before dissemination is impractical and inappropriate. It is not feasible for the Trust Director of R&D to have oversight of communications both written and oral before they are disseminated.
- (iii) The research management plan: I believe that the same principles should apply to block contracts for R&D within the NHS as are applied within the university sector, or similar. Whilst the funding clearly reflects the programme of work in progress, and projected, it should not be inappropriately tightly linked to this. The Trust or other research provider should have the opportunity to develop its research strategy and use the funds as appropriate to support the necessary service costs, projects and programmes within the overall capsule of its R&D activities.
- (iv) The R&D carried out by the Trust will be mainly of importance to the NHS, but it is important to pay tribute in the contracts to service support for biomedical and clinical research sponsored by other funding bodies, as specified in the Culyer report.

5. Pre-protocol and curiosity-driven research

On re-reading the Culyer report, I am not sure that we achieved as much clarity on our commitment to this as I would have liked. It has been suggested that the reference to pre-protocol and curiosity-driven exploration in para 3.36 suggests that this might only occur as part of implicit research, to be funded out of purchaser or provider's own funds (ie not via the central levy).

I do not believe this was our intention. Thus I interpret para 3.45 (R&D consists of a range of activities which take shorter or longer times to produce results, and carry more or less risk of failure) to include also pre-protocol and curiosity-driven research. This "blue skies" research would thus be entirely appropriately covered by the three categories of funding for R&D in the NHS (3.46). Such research should also appropriately be supported in institutions with large research portfolios and one "bundled contract" (para 3.47).

6. Peer Review (3.86-87)

I subscribe to the principles of peer review espoused by the NHS R&D programme and in the Culyer report. However, there are difficulties with peer review, including competence, consistency, perceived jealousies and not least the time involved. Outcome peer review (the achievements of an individual, group or institution as in the RAE exercise) is more robust than prospective peer review (project and programme applications, future aspiration, curiosity driven research etc). We need more thought and work on evaluating the peer review process itself and judging when and how it is best applied. In the meantime, outcome peer review should continue as the major part of the judgement process. This is particularly important for facilities support, and large "rolled-up" contracts.

7. Funding

The terms of reference for the Culyer report precluded the question of overall funding for R&D in the NHS. Nevertheless this is of critical importance for the future health of medical R&D. There are dangers:

- (i) Implicit research and its funding may not be adequately identified. This type of research could well be squeezed out. The Culyer report does address this issue (para 3.34-3.38).
- (ii) The shift to new priorities may damage currently funded activities, particularly the NHS service costs associated with biomedical research, and clinical research generally. There will be ever increasing calls on the R&D funds for research into new areas, and in new ways. Examples may include research into complementary medicine, into the dissemination and implementation process, into the social aspects of health (such as the interaction between poverty and health), the politics of health etc. Each of these is maybe highly appropriate, but it would be a tragedy if continual identification of new priorities led to the progressive demise of biomedical and clinical research.

For these and other reasons, adequate, and increasing, funds must be made available for R&D in the NHS. I welcome the Secretary of State's commitment to increasing SIFTR (and the R of SIFTR) as well as to increasing year on year the funds for R&D. It is vital that this commitment be continued progressively and in the long run.

7 February 1995]

[Continued

It is important to urge that funding for R&D as a percentage of NHS budget should continue to increase and should at least reach the 1.5 per cent target. It is possible that this will allow the present scale of clinical and biomedical research to be supported (albeit not necessarily by the same people/institutions), as well as providing resources for increased activity in health service, primary and community research and other areas. Inexorably however, there will need to be broad priority settings. It is important that transition phases be sufficiently long, and sensitively handled.

III LONDON MEDICINE

The question of whether London's medical institutions needed realigning is behind us. Certainly there did/does appear to be too many small and medium sized specialist units in a relatively small area (eg radiotherapy, renal units, cardiac surgery etc.) and the practice of medicine is changing (eg keyhole surgery). We now need to be positive and to build for the future. The vision of four large medical schools with undergraduate and postgraduate breadth and depth in teaching and research has been with us for 20 years or more. It is now on the verge of achievement.

It is vital that all parties, including the government and the medical community do everything they can to make these visions a reality. The worst outcome would be if the pain of the last two to three years did not lead to the projected gain.

Some of the current difficulties include:

- (a) Money on the table. This is needed to fund the change process itself, the capital costs and interim revenue requirements. Change/merger/downsizing of institutions involves short term costs. There may be long term gains, but the short term costs must be fully funded or demoralisation sets in and the long term gains are not achieved.
- (b) Management of change requires the time and commitment of full-time individuals. It is hard/impossible to manage major change at the same time as managing large complex organisations. More resources in terms of people and time should be devoted to managing these complex changes across London. The London Implementation Group (LIG) has played a part in this, but there needs to be more work at local levels. LIG is to be disbanded, and it is not clear that the Regions have the resources to manage these complex changes effectively. This problem may be enhanced from April 1996, when the new downsized regional offices come into play.
- (c) There needs to be matching commitment from the medical community to make the new arrangements work. On the whole this commitment does exist, but there are frustrations, relating to (a) and (b) above.

The problems of London's medicine are being faced by other large cities in Britain, and indeed around the world. Thus, for example, the Massachusetts General Hospital in Boston is currently facing the task of reducing its bed numbers by 50 per cent. Paris, New York, Sydney and others have to make similar readjustments.

London's medicine suffers from some national prejudices, which are less appropriate now than perhaps in the past. There is a perception that London has been over-provided with medical and research facilities, at the cost of the rest of the country. London is the major conurbation serving the South East of England.

The Thames Regions alone contain 27.4 per cent of the population of England (29.6 per cent of "weighted" population). There has been an implicit and sometimes explicit commitment to shift resources away from London in the last decade or two, in medicine as in other areas. This process has gone far enough, and London should now be allowed to compete nationally on a level playing field. The perceived bias of organisations such as the British Council, the MRC and others against London should be abandoned. London should receive neither positive nor negative discrimination.

The advantages that London brings to employees in facilities and quality of living, easy communication and interaction with other workers etc. should be noted. Most civilised countries take pride in their capital cities, and are at pains to cultivate them and enhance them. We should not allow the immense benefits of London, a great British national asset, to be dissipated.

London still represents one of the world's greatest centres of medicine, including biomedical research, education and clinical practice. I would like to see us capitalising on and enhancing this critical mass of expertise and talent. We should be making widely known the achievements and potential of London's medicine, so as to attract research investment, students and clinical practice not only nationally, but especially from abroad. The organisation London First is taking up the cause of London's medicine, and I would like to see the medical community, managers and the Government giving these initiatives their strongest support.

January 1995

7 February 1995]

[Continued]

REFERENCES (not printed):

- (1) John H James, "Purchasing research in the NHS" *Journal of the Royal College of Physicians of London* 1994 Vol. 28 No. 5 (390-391).
- (2) Letters "In response: Purchasing research from or for the NHS" *Journal of the Royal College of Physicians of London* 1994 Vol. 28 No. 6 (494-497).
- (3) Dr Malcolm Green "London after Tomlinson: Clinical Research" *British Medical Journal* 1992 Vol. 305 (1,081-1,085).
- (4) Professor D G Grahame-Smith "KO'd by R&D speak: deciphering Culyer" *The Lancet* 1994 Vol 344 (1,452) 1994, and replies *The Lancet* 1994 Vol. 344 (1,774-1,775).
- (5) "What seems to be the matter? Communication between Hospitals and Patients" Audit Commission, National Health Service Report 1993 No. 12 HMSO.
- (6) Agreement between the Secretary of State for Health and the Great Ormond Street Hospital for Children NHS Trust.

Examination of witness

DR MALCOLM GREEN, Director of the British Postgraduate Medical Federation, was called in and examined.

Chairman

598. Good morning, Dr Green. I would like to give you the opportunity of making an opening statement about the BPMF for the benefit of non-medical members of the Committee.

(Dr Green) Thank you, my Lord Chairman. I am the Director of the British Postgraduate Medical Federation. I think you have been circulated with a brief summary from the recent HEFCE survey of HEIs about what we do. We were established in 1945 and our current remit is to look after the seven postgraduate research institutes associated with the ex-SHA hospitals. We also have a responsibility for the Deans of postgraduate medicine and dentistry, elsewhere called Postgraduate Deans, who cover the training of doctors, dentists and general practitioners in the two Thames regions, about 30 per cent of the doctors and dentists in training in the country. Those are our two remits. The Institutes are closely associated but, of course, independent from the ex-SHA hospitals and a number of your questions, my Lord Chairman, relate I think to the ex-SHA hospitals and I am happy to discuss those because, of course, we have very close, indeed intimate, interactions between the Institutes and the Hospitals.

599. And the relationship of the Institutes with the University of London?

A. The BPMF is a School, now a College, of the University of London so the Institutes by being part of BPMF are part of the University of London.

600. To look into the future, now that a number of these Institutes, are becoming associated with multi-faculty colleges of the University of London and the hospitals are undergoing a process of merger with certain other major teaching hospitals and trusts, what do you see as being the future of the BPMF?

A. The Institutes are all in the process of joining in one form or another with multi-faculty colleges, so the seven institutes will have left BPMF by 1st August this year. The ex-SHAs, the hospitals are, or will be, I think, Trusts. They are therefore independent trusts but they will remain extremely closely linked to their Institutes but their Institutes are transferring from our care to the care of multi-faculty colleges.

601. So when all this process is completed is it likely that the BPMF will cease to exist?

A. I think that depends on the future of Deans of Postgraduate dentistry and medicine but certainly its responsibility for the Institutes will finish by the end of this year.

602. Would you remind us, under the interim arrangements for the funding of the former special health authority hospitals: for how long is their funding to be protected with the £250 million for research that we heard about earlier this morning? When will they become totally dependent on the internal market and on support from Culyer?

A. The funding of the ex-SHAs—shall we just call them SHAs for convenience sake?

603. Yes.

A. The funding of the SHAs, although they are now trusts, is complex in the extreme.

Lord Gregson

604. You can say that again!

A. Just to simplify it I think there are three major funding streams currently. One is a funding stream which is purchasers buying patient care in the open market, the internal market. One is a central subvention, subsidy, which in due course will be taken over, I think, as part of the Culyer Levy. The third is a transitional arrangement of monies which were originally called CASPE monies and now have another name, which is a subvention enabling purchasers to continue to purchase patient care at subsidised prices. That subvention is falling away over the next four years. I think if we leave the CASPE subvention out, because that is just a transitional arrangement, in the future there will be two funding streams, one is the funding stream from the internal market, and the other will be the funding stream from what we might call the Culyer Levy.

605. Do you see at present an effect upon the ability of these hospitals and institutes to conduct research arising from their entry into the internal market, and in particular have they experienced serious problems in relation to extra-contractual and tertiary referrals from district general hospitals?

7 February 1995]

DR MALCOLM GREEN

[Continued]

[Lord Gregson *contd.*]

A. Can I take that in two parts.

606. Please.

A. The ex-SHAs were extremely anxious at the time of their negotiations two years ago as to their future funding and at one stage there was a suggestion that they should go wholeheartedly into the internal market even before the Culyer type arrangements were in place. Had that happened I think all the ex-SHAs would have come to a rapid demise. In the event, the arguments that the SHAs put that they were a national resource and that it was vital that their central core funding essentially for R&D should be protected, that argument prevailed and the arrangements which have put in place, the transitional arrangements, are in my judgment entirely appropriate. So the ex-SHAs have been in a position where they have been able to enter the internal market with a sufficient subvention for R&D to be able to take forward their aspirations. There are severe dangers though, in coming to the second part of your question, there are severe increasing difficulties with the problem of patient flows. This problem of referrals, I think, is a very important one which will crucially affect the SHAs but also all research active hospitals in the future.

Chairman

607. Yes.

A. There are a number of factors, that influence the pattern of referrals: cost, quality, information about services available, local contracts, loyalties and so on. Indeed, you had a discussion with Professor Culyer and his group about this last week. I think that the solution to this problem for research active hospitals is likely to come at a number of levels. The first is that it is good that purchasers are required to pay for these referrals if made from doctor to doctor and the purchasers nominally have no influence over how these referrals are made. In practice there is evidence that there is considerable pressure by purchasers at least for such referrals to be very strongly justified and maybe even to keep them to the minimum. This represents a problem. So in that context I would like to see a very much stronger drive on purchasers for considerations of quality, of clinical quality, to be driving their purchasing decisions. That would be my first comment. The second is that I think the possibilities that have been floated for purchasers getting together with mutual or insurance schemes for rare and complex cases might well also have merit because that would take the cost of any one individual extremely rare and/or costly patient away from the individual purchaser into a more corporate or more general funding scheme. Thirdly it is important for specialist centres to make more clearly known the types of patients that they can provide for and the uncommon and rare disorders for which they are able to provide specific services and/or which they need for their research services. There is a need for communication there. Finally, my Lord Chairman, I think that it is important that research active hospitals be able to subsidise the costs of these patient flows. This brings me to the single most important point that I would like to present to your Lordships and that is the

question of how a research active hospital is able to treat, to deal with, its packaged contracts money, its facilities funding, etc. That is an issue that I would like to expand on if I may, Chairman. Do you want me to do that now?

608. Please do.

A. I mentioned in my evidence to you, my Lord Chairman, about the package contracts and the importance with which I view facilities funding. It is clear that package contracts and facilities funding will be built up on the basis of Thompson-type reviews of the programmes and projects the institutions are undertaking and a whole number of other factors which will lead to a sum of money being identified as the infrastructure or facilities funding and funding for the programmes and projects all wrapped up into one sum of money to be allocated to the research active hospital. That system is very similar to the funding system that HEFCE applies for the universities at present. I think the crucial next step is that that sum of money be delivered to the research active hospital (and/or medical school), and that they in their turn be allowed to use that money to take forward their strategies for NHS R&D and service costs of R&D in the NHS within their institutions. It is absolutely fundamental that they should have flexibility to use that money appropriately. I am worried that at the moment within the SHAs, while lip service is paid to that flexibility, at the grass roots level there is a strong implication that a sum of money based on a specific piece of research with this rating and with this particular relevance to the NHS, must go to that specific research area. This, I know, is not what happens to the HEFCE funding when it goes to universities, where it is not earmarked I believe it is absolutely vital that Culyer levy money should similarly not be earmarked. Just to expand on that, it is of course vital that this money be fully accountable but there are different types of accountability. There needs to be accountability that the money has been appropriately spent, spent on NHS activities, not spent on things without the appropriate use of public money in this sector. That type of accountability comes from internal audit, external audit and so on. I believe that the accountability for its use within the NHS R&D strategy generally should come at the next Thompson-type review.

609. Yes.

A. And at the next review the institution would be judged as to whether it had spent its money wisely or not wisely and if not wisely it would get less money next time round, if wisely it would get more money.

610. Just to clarify exactly what you mean by this: you are in favour of the proposal that one of your SHAs might get an overall block grant for research from Culyer, but you are against earmarking of that money within it to specific subsections of the institution, that is your concern?

A. Exactly.

611. Do you, nevertheless, see a case for separating that funding, on the one hand into R&D for health services research and, on the other hand, for the infrastructure facilities for biomedical research?

7 February 1995]

DR MALCOLM GREEN

[Continued]

[Chairman *contd.*]

A. I would separate out the NHS commissioned R&D.

612. Yes.

A. So if Michael Peckham—

613. At central or regional level but not at hospital level?

A. Any purchaser, including the NHS, who purchases an R&D programme or project is entitled to expect the money for that programme or project to be spent on that programme or project. So if the NHS R&D Director purchases a specific programme: "I want you to look into the effect, let us say, in hospitals of bed sores", then it is appropriate that the money allocated to that project should go to that project. So I would put aside NHS commissioned R&D. The NHS in that sense is a commissioner like any medical research charity, like Wellcome and all of those commissioning research, in reflecting that research money for the R&D must go to that particular project.

614. Yes.

A. What I am talking about is the facilities' support, the infrastructure support and the service costs.

615. Thank you. That is clear.

A. My Lord Chairman, coming back to the question of recruiting patients, I think it is vital that research active hospitals should have the freedom to be able to subsidise the service costs of particular groups of patients. They may subsidise their costs partially, completely, they might even have them free, in fact it is even conceivable that they might wish to subsidise so that actually they are paying for those patients to be seen. That should be a freedom within the strategy of the research active hospital.

616. Where do you identify the pressure for earmarking within institutions? Is this coming from managers or from the researchers themselves?

A. I think, my Lord Chairman, I circulated to you the agreement between the DH and an ex-SHA.

617. Yes.

A. That agreement is a lot less prescriptive than the original agreement sent by the Department of Health to the SHAs and the SHA agreements are different from SHA to SHA for reasons that I am not clear. Whilst this is a lot less prescriptive than it was in its draft form it is still fairly prescriptive. Schedule 3 lists the scientific quality and the NHS relevance of different projects. There have been people from the Department of Health who have been coming round at the annual review asking the SHAs how the spending of their money relates to the list of projects. I do not think that perspective is shared necessarily throughout the Department of Health but the practicality is that that is very easy for the recipient to believe, and for the people charged with reviewing this process to reinforce a perspective that the money is closely linked to each and every one of these projects. That is what I feel would be very inhibiting.

618. Do you have any comments yourself upon notification before dissemination?

A. Yes, my Lord Chairman.

Lord Gregson

619. Before we change the subject, can I just come back to this question of what I call patient flow, let us call it centres of excellence. There are so many forces now acting against it that you have really got to take special measures to make it happen. The contracts between the purchaser and the provider are strong incentives not to deflect any patients out of the system. Also, the other source is tertiary referrals. That is beginning to dry up because trusts are very reluctant to transfer their patients to another trust because that is their money going. Some of them have to create a situation whereby there is some incentive for those patients to be transferred. When I looked at a particular centre of excellence a lot of the people who came in as patients were out of the medical profession because they recognised that they were going to get the right treatment, that was the right place to be. In order to get yourself nominated out of the contract you have got to be a fairly influential person with the local practice. You have almost to kick them in the teeth and say: "I want to go there". Patient choice is a very important factor in that and that is being very heavily suppressed at the present time as you probably realise. Do we not need definite incentives to provide the patient flow necessary for the research programme? It is all right spending money on research programmes but if you do not then cater for the patient flow you are throwing your money away.

A. My Lord Chairman, I agree totally. I did list the five measures that I think could help address that issue. I would be happy to perhaps enlarge on them a little in written evidence to your Committee afterwards.

Chairman

620. Thank you.

A. I do think the question of driving purchasers down the quality route is one way of helping it.

Lord Gregson

621. More important in many ways is the tertiary transfer because the problem has been recognised and the importance of specialisation has been recognised at that stage. The GP does not necessarily recognise that situation. It is like drawing teeth out of a hospital trust to get a patient and when you get it out of them they do not pay you, they muck up the paperwork. Is there not some incentive required at that level?

A. I think there are incentives required at each level, my Lord Chairman.

Chairman

622. We can see how it would be possible in the proposals you and others have put forward to use part of the "R" funding stream for Culyer to reduce the actual cost of a referral to a specialised centre but that does not overcome the situation that may arise if the cost of treating the patient with a rare or a common condition in a specialised centre is thereby

7 February 1995]

DR MALCOLM GREEN

[Continued]

[Chairman *contd.*]

reduced to the same cost as it would be in a district general hospital because even if that reduction is achieved what would then be the incentive for the district general hospital to refer the patient?

A. Yes. My Lord Chairman, I agree. I think two things. I think firstly the quality comment. I believe purchasers are now focusing, but I would certainly welcome them being encouraged to focus more on quality as well as on quantity and cost. Secondly, I think it should be within the remit of a research active hospital to reduce that cost below that of a district general hospital, or even to zero, but of course that does bring us to the question of the overall costs of the subvention to research active hospitals which is another topic I would like to expand on at some stage, my Lord Chairman.

623. Do you then see a case for a limited number of research beds or a limited number of designated out-patient clinics paid for from the "R" stream in specialised centres?

A. The short answer is no because I would like to see research active hospitals having a major, or in the case of substantially research active hospitals a total, commitment to the research ethos throughout the hospital. I think you could argue that in an ideal world every patient who goes to one of the SHAs should be seen as part of that SHA's research commitment. I would be reluctant to see a ward with three beds in the corner, the research beds, and 15 beds elsewhere, the non-research beds. I would prefer to see the subvention for the research active hospital research in the NHS, the service costs of the R&D in the research active hospital, to be spread so as to enable the entire organisation to pursue and achieve its research strategy.

Lord Gregson

624. The question of research beds is merely a notation. Out of 200 or 300 beds it is a way of paying a subvention. Where the beds are physically has nothing to do with it in effect.

A. I am in favour of other purchasers other than the NHS being asked to contribute to the service costs of R&D. I think there is no reason why charities, for example, although some of the charities do already—

625. Yes, they do.

A.—contribute to the service costs of R&D. There is no reason why an agreement/contract with such a purchaser or with industry or anyone else should not be quite specific. The hospital would agree to service 12 patients a week or a year or whatever it is. Maybe we are one, my Lord Chairman, except for the notation of research beds. If we call it a research subvention or service costs of research subvention then I think we are probably all at one.

Lord Gregson] The problem within the trusts is how you cost that subvention. The convention is to call them research beds but it does not mean a thing quite frankly in the physical situation.

Chairman

626. Let us go back to the question about notification before dissemination.

A. I would deplore it, my Lord Chairman. I think it is totally impractical. As soon as you start to dissect it you have to ask what do you mean by dissemination: is it presentation of the work at an international meeting or a local meeting, internal or external? How do you decide if the work you actually present is slightly different from the abstract? I think it is impractical, my Lord Chairman, and inappropriate. I think research has to be fostered in a spirit of international freedom, of intellectual endeavour.

627. And the flow of scientific papers from some research orientated hospitals is so huge that the Department would have to set up a major organisation to be able to cope with it.

A. Paperwork can be quite impossible. I think it is the sort of aspiration which I would strongly recommend should not in any shape or form go into documents because then it creates a false expectation on both sides, quite apart from being inappropriate.

Lord Nathan] Lord Chairman, talking about the application of charity money, research is only a charitable purpose to the extent to which there is dissemination of the fruits of that research.

628. Exactly. Now comments about London reorganisation: any lessons that this may give us for other urban clinical academic centres?

A. Yes, my Lord Chairman. I suppose change is inevitable, that is one lesson. It is probably right to work with change as far as is possible. I think if I had a few messages they would be, firstly, that change costs money. The process of doing the change, both implementation and getting to where you want to be, amalgamating two institutions, moving this department, whatever it happens to be, costs money. There may be long-term gain but there is usually short-term cost. The danger is that those who wish to see the change achieved recognise the long-term gains without adequately identifying the short-term costs. I would say change costs money. The second thing is the time frame can appropriately need to be quite long if at the same time you want to keep the institutions or activities going.

629. Yes.

A. There needs to be appropriate timing. The service change must match academic and research change. I was talking to the senior manager of one of the SHAs yesterday and he said that one of the things that had come over so powerfully in London was the research dimension which in a managerial frame, although it had been there, had not really surfaced as one of the key drivers of the change. I think research as a driver would be my fourth comment.

Baroness McFarlane of Llandaff

630. Can I ask who has been bearing the costs of those changes as far as the Federation is concerned?

A. The costs of our changes are relatively modest, hundreds of thousands rather than tens of thousands, maybe more, but not decades of millions.

7 February 1995]

DR MALCOLM GREEN

[Continued

[Baroness McFarlane of Llandaff *contd.*]

631. That is the cost to the institutions?

A. There is no physical relocation: it is a relocation of allegiance for us. Even so the costs are significant and the answer is that it is quite difficult to find the source of such funds. Because these are realignments rather than relocations the costs have generally had to be absorbed mostly within the institutions. When it comes to relocations some money may be available but I get the feeling that the jury is still out on that. I am not sure for example that the money has been fully identified for a new pre-clinical science building at Imperial or the new medical school at the London. I do not know that the money is actually on the table yet so we will see. I am not competent to talk about that.

Chairman

632. You implied in your memorandum that you see a potential danger that the directive nature of the NHS R&D strategy and some of the other recommendations of Culyer could perhaps, unless very carefully implemented, be to the detriment of clinical biomedical research in favour of much more support for health services research. Do you see this as a serious danger?

A. My Lord Chairman, I think the move towards health service research is one that I support but I think it is vital that that move should not cause

damage to the United Kingdom clinical research and biomedical science base.

Lord Gregson] What would be your comments about separating them so there is, if you like, a social research base and a clinical research base?

633. Two funding streams from "R"?

A. I think I would like to think about that. In general I go back to my policy, to my thesis, that what I would like to see is research active hospitals and research active institutions generally which have flexibility within them. I hope that we will be able to argue that the NHS should spend sufficient of its money in this hugely important area of R&D that it should be able to support both excellent biomedical and health service research. I would like to have the best of both worlds.

634. Do you see it as being a requirement as Culyer recommended—this is challenged by the AMRC—that all project grants should first require approval from the NHS providers?

A. If they consume NHS resources (a) I see no difficulty and (b) I think it is desirable.

635. You think it is reasonable?

A. The same thing happens on the university side.

Chairman] Yes, it does. We are very grateful to you for your memorandum and for coming along and meeting us this morning.

MINUTES OF EVIDENCE
TAKEN BEFORE

**THE SELECT COMMITTEE ON SCIENCE
AND TECHNOLOGY**

**(SUB-COMMITTEE I: MEDICAL RESEARCH AND
THE NHS REFORMS)**

Tuesday 14 February 1995

QUEEN'S UNIVERSITY OF BELFAST

*Sir Gordon Beveridge, Professor R W Stout, Professor R J McClelland
Professor E Trimble, Professor R G Shanks, Dr G A Baird
and Mr J O'Kane*

**NORTHERN IRELAND DEPARTMENT OF
HEALTH AND SOCIAL SERVICES**

*Dr J J M Harbison, Dr C Hall, Mr P Simpson
and Mr R Beckett*

Printed pursuant to the Order of The House of Lords 22 November 1994

LONDON : HMSO

£7.50 net

TUESDAY 14 FEBRUARY 1995

Present:

Butterfield, L.
McFarlane of Llandaff, B.
Perry of Walton, L.

Walton of Detchant, L.
(Chairman)

Memorandum by the Queen's University of Belfast

NHS RESEARCH AND DEVELOPMENT IN NORTHERN IRELAND

Northern Ireland is behind the rest of the United Kingdom in introducing a research and development strategy in the Health and Personal Social Services (HPSS). In 1993 a discussion document was issued and widely circulated to interested parties. This suggested a structure for an HPSS Research and Development Strategy for Northern Ireland and the appointment of a Director of Research and Development. A large number of submissions were received by the DHSS but no definitive policy has been produced and Northern Ireland does not have an HPSS Director of Research and Development or a Regional Research Committee. We believe it is essential that the Research and Development Strategy for Northern Ireland and the post of Director of HPSS Research and Development is introduced as soon as possible. It is essential that the person appointed to the post of Director of Research and Development should be somebody of high academic standing with an excellent research record and independent of the DHSS. Such a post would be essential if Northern Ireland implements the recommendations of the Culyer Report. An issue that needs to be decided is whether Northern Ireland will lead a particular area of HPSS research and development, as has happened in the English regions, or whether it will attempt to encompass the whole range of HPSS research and development. It would be of great advantage if at least one member of the Central Research and Development Committee came from Northern Ireland.

THE CULYER REPORT

The Culyer Report only applies to England but if past experience is repeated it will, perhaps in slightly modified form, be introduced into Northern Ireland in due course. As indicated above, the absence of a Director and Committee for NHS Research and Development makes the current introduction of the recommendations of the report difficult.

There are some areas of particular concern to the University. The first is the fact that 25 per cent of STAR (Supplement for Teaching and Research), which is Northern Ireland's equivalent of SIFTR, will be removed and put into a single funding stream for research. It is important that this funding should be retained within Northern Ireland. If this is used to support projects in primary and community care, it will result in a transfer of funding from hospital to elsewhere and this clearly will have an impact on hospital resources. Since the two major Belfast teaching hospitals, the Royal Victoria Hospital and the Belfast City Hospital, are the major recipients of STAR funding, they will be most affected. If research funding follows research activity, most of the money will in fact return to these hospitals.

It is proposed that research supported by the HPSS should be assessed. Much HPSS Research and Development is undertaken by or in close association with university clinical departments which are already subject to the Universities' Research Assessment Exercise. This is a heavy administrative burden and it is important that the system for health service research assessment is closely linked with the university system. It is also essential that, as with university research, Northern Ireland HPSS Research and Development should be assessed by national panels.

Currently around £400,000 per year is allocated by the DHSS (NI) for the support of clinical research. This supports research fellowships which allow doctors at registrar level to take a year or sometimes more out of clinical work to engage in full time research and also supports a considerable amount of research, both in the universities and in the hospitals. It is essential that under any new funding mechanisms, this support should continue.

THE NHS REFORMS AND CLINICAL RESEARCH

Some concern must be expressed about the effect of NHS reforms on clinical research. This applies to both clinical trials on common conditions and on the detailed study of uncommon conditions. The disincentives for general practitioners to refer to hospital and for tertiary referrals from smaller hospitals to teaching hospitals could mean that finding the necessary numbers of patients for these studies becomes more difficult.

14 February 1995]

[Continued]

A further consequence of the NHS reforms is threat to the large, usually inner-city, teaching hospitals with their concentration of general and specialist clinical services, laboratory and imaging departments, and associated medical school research facilities. Academic medical centres of this type have made many important contributions to medical knowledge. It is unfortunate that as high quality medical research becomes more dependent on a "critical mass" of researchers, equipment and opportunities, academic medical centres are under threat of becoming dispersed and disbanded.

Further memorandum by the Queen's University of Belfast

INTRODUCTION

1. Please introduce yourselves, and outline the activities of Queen's University in the area of medical research.

Queen's University is heavily involved in medical research, most of it being carried out in the Faculty of Medicine. The Faculty of Medicine has four Schools: Clinical Medicine, Clinical Dentistry, Biomedical Science and Nursing, as well as the Institute of Telemedicine and Telecare, and the Health and Health Care Research Unit.

In the School of *Biomedical Science* research is related to basic medical sciences and the strengths are in cardiovascular physiology including study of the lymphatic system. The research of the School of *Clinical Medicine* has been grouped into five areas:

- Metabolism and Endocrinology is a strength and particularly notable are the Wellcome Laboratories which carry out research on neuropeptides and comparative neuroendocrinology. A number of new neuropeptides have been identified, particularly in helminths and there is collaboration with the School of Biology and Biochemistry. Other strengths are in diabetes, lipid metabolism, free radicals, and in gastroenterology. A particular strength is in Ophthalmology which has recently received major grants from both the MRC and the Wellcome Trust and carries out research on diabetic eye disease as well as other visual impairments.
- Molecular Medicine is concerned with research in Medical Genetics identifying genes responsible for common diseases, particularly bone disease, renal disease and cystic fibrosis. It also cooperates with Oncology and Biochemistry on a major study on the genetic basis of ovarian cancer. The Cancer Research Campaign has recently raised funds for a new laboratory and a new Professor of Oncology is to be appointed in the near future. The Department of Medical Genetics collaborates with many other subject areas in research into the molecular genetic approach to disease.
- Clinical and Molecular Pharmacology undertakes research in basic and clinical pharmacology particularly in cardiovascular drugs. This includes basic research, such as studies in cultured cardiomyocytes, pharmacokinetic studies and studies of the regulation of the vascular system in conditions such as hypertension, diabetes and hypercholesterolaemia. Anaesthetics is part of this research area.
- Pathogenesis includes the Department of Surgery which has a major research programme on the metabolic effects of trauma, sepsis and surgery, and the role of cytokines in these conditions. Research studies in Pathology and Microbiology also take place with particular strengths in collaborative studies in Neuropathology.
- Epidemiology and Health Care Research includes the Department of Epidemiology which is a component of the MONICA and ECTIM studies and has made major advances to knowledge of the epidemiology of cardiovascular disease. There is also research in genetic epidemiology. General Practice collaborates in multi-centre studies headed by the MRC. Mental Health is involved in outcome studies in psychiatric illness and Geriatric Medicine in studies in Alzheimers disease, seasonal variation of disease and characteristics of the oldest old. Recently developed research units in this area are the Health and Health Care Research Unit, the Northern Ireland Cancer Registry and the Institute of Telemedicine and Telecare.

The School of *Clinical Dentistry* is becoming more active in research. The School of *Nursing* was established three years ago and its major task is the integration of nurse education into the University.

2. Please tell us about Queen's University's Health and Health Care Research Unit. What does it do, for whom, and who pays for it?

The *Health and Health Care Research Unit* was established six years ago as a joint initiative between the DHSS(NI) and Queen's University. The initial contract provided core funding for five years which paid for the salary of the Director and some staff, while the University provided accommodation. The aim was that after five years the Unit would become self-sufficient from contract income, principally from Health Service purchasers and providers. The Director is responsible to a Management Committee which is jointly staffed by the University and the DHSS and chaired by the Dean of the Faculty of Medicine. The Unit has had rather uncertain beginnings partly because the Health and Social Services Boards were not particularly interested

14 February 1995]

[Continued]

in contract research but tended to set up their own research departments and hence contract income was not as much as expected. Second, the first two Directors stayed for relatively short periods of time until they were head-hunted to prestigious posts in London. A new contract has now been negotiated which provides for a rolling programme of core support from the DHSS, and the University is also contributing to funding the Unit from DENI development funds. A new Director took up office on 1 July 1994 and is recruiting senior staff. We expect the HHCRU to set off on a new beginning and to become much more productive. There is considerable potential for health service research in Northern Ireland with its stable population and unique integrated health and social services management arrangements. The HHCRU has already completed some important studies including one of community care.

3. *Please tell us about the Drug Utilisation Research Centre, and the Cancer Registry at Queen's University.*

The *Drug Utilisation Research Unit* was established to integrate work which had taken place in Queen's and the DHSS for many years on drug prescribing. It is situated in the Department of Therapeutics and Pharmacology and is funded on a rolling grant basis by the DHSS. It carries out studies on drug prescribing, is staffed by a Director who is medically qualified and seconded from the Department of Health, and five other members of staff funded through the grant to the University. Accommodation is provided by the University in the Department of Therapeutics and Pharmacology. The Unit analyses the prescriptions written by General Practitioners in Northern Ireland and provides detailed prescribing information on all drugs and relates this to General Practices and Boards. With the demographic details of patients it enables detailed studies to be made on prescribing habits. It also provides detailed information to the Boards to enable decisions to occur about ways in which drug prescribing could be more effective and more economical. The *Northern Ireland Cancer Registry* is the culmination of a number of efforts at cancer registration that have taken place over the years. For various reasons these were not entirely satisfactory and it was felt that a new beginning was needed. The Cancer Registry is jointly funded by the DHSS and the Ulster Cancer Foundation and is part of the Department of Epidemiology and Public Health in the School of Clinical Medicine. It was established two years ago and the first Director took up office last year. Funding for the Registry is currently for five years but it is anticipated that it will be renewed. The Director is setting up systems of cancer registration and it is envisaged that one or two smaller specialised cancer registries, such as the colorectal cancer registry and the melanoma registry, will in due course be incorporated. The Cancer Registry will act as an important source of information to purchasers of health care but will also be a research resource in the epidemiology of cancer. As mentioned under 1 a new Professor of Oncology is shortly to be appointed and we anticipate that there will be close collaboration between the cancer registry and other research in cancer.

4. *According to the Consultative Paper of 1993, medical research in Northern Ireland benefited "only to a limited extent" from MRC support. What is the position today? And how much support is received from charities, industry and the EU?*

In 1993 the Faculty of Medicine earned research grants and contracts of £4.1m; of this £83.5k (2 per cent) was from the MRC, £1.6m (40 per cent) from UK based charities, £0.4m (10 per cent) from industry, £0.1m (3 per cent) from EU. Of the remainder £1.5m (37 per cent) came from government and health board sources. The reasons for the limited support from the MRC are probably multiple. One is that the support is difficult to obtain and researchers tend to become discouraged. Staffing levels in the Faculty of Medicine are relatively low and clinical academic staff have heavy clinical and teaching loads. Information suggests that our success rate is about the same as elsewhere but our application rate is very much lower. There are a number of health related charities in Northern Ireland which are very generous in their support of medical research and as a result there is less pressure on academics to seek MRC support. We are endeavouring to change this and to encourage researchers to see local charity funds as seed corn on the basis of which applications for major grants can be mounted. Industrial support for medical research in Northern Ireland is also relatively small apart from pharmaceutical companies. There is little support from the EU for medical research in Northern Ireland.

5. *What is the nature and extent of collaboration in the funding and conduct of medical research between Northern Ireland and the rest of the United Kingdom, or the Republic of Ireland?*

Northern Ireland academic clinicians participate in multi-centre studies with the rest of the United Kingdom and beyond. There are close personal links between many of our researchers and those in the rest of the United Kingdom and our researchers find it easy to visit laboratories and gain expertise. There are few if any formal links and no formal funding collaborative arrangements with the Republic of Ireland but a relatively small amount of personal collaboration in research. New collaborative links are being developed by the Institute of Telemedicine and Telecare and under the EU IV Framework.

14 February 1995]

[Continued]

R&D STRATEGY

6. (*Professor Stout*) According to your memorandum, "It is essential that a R&D Strategy for Northern Ireland and the post of Director of HPSS R&D is introduced as soon as possible". Please explain why you consider this to be so important.

Northern Ireland is the only part of the United Kingdom that does not have an R&D strategy or a Director of HPSS R&D or equivalent. We are disadvantaged in this way and there is not the same opportunity for us to obtain health service support for R&D. If, as we expect, Northern Ireland adopts the principles of the Culyer Report in due course, then it is essential that a Director of HPSS R&D is in post to assign the funding for research and produce policies. It is our view that a Director should be a person with a distinguished record in academic medical research.

7. *Would you prefer Northern Ireland to be part of the priority-setting processes of the NHS R&D Strategy, with representation on the CRDC and lead responsibility for particular areas of research; or would you prefer a distinctly Northern Irish R&D Strategy with its own priorities?*

Northern Ireland is a small region with a population of only 1.5 million and a relatively small R&D budget and it would be impossible to cover all areas of HPSS R&D. It would be better in our view if Northern Ireland had lead responsibility for a particular area of research, one that was particularly relevant to Northern Ireland eg: community care. Northern Ireland should be represented on the CRDC.

8. *Are you affected by the R&D activities of the four Health Boards?*

The R&D activities of the Health Board are relatively minor. Some Departments have contracts for research from the Eastern Health and Social Services Board, particularly in the fields of Mental Health and Telemedicine. The Health Boards should be encouraged to develop their research activities and in particular to contract with the University for research rather than set up their own research in parallel.

9. *Are you affected by the Research Strategy and Action Plan of the National Board for Nursing, Health Visiting and Midwifery?*

The Northern Ireland National Board does not have a Research Strategy. There is a DHSS (NI) Nursing Research Strategy which is currently being redrawn. The School of Nursing fits in with this Strategy.

10. *What links have you developed with (a) the Cochrane Centre, (b) the York Centre for Reviews and Dissemination and (c) the Leeds Clearing House on Health Outcomes?*

None.

RESEARCH

11. *In England it is proving difficult to sustain the patient flows required for research. Is this happening in Northern Ireland too? Please give examples. What is the way forward.*

Northern Ireland is a year behind the rest of the UK in implementing the health service reforms. We have not been aware of any problems to date. It seems likely that for certain common diseases eg: hypertension, the numbers referred to hospital may decrease and in particular GP fund holders may be discouraged from doing so. The way forward is to collaborate with General Practice and undertake research in the community.

12. *Are there any plans to set up "research beds" in Northern Ireland?—ie clinical research facilities with excess service costs paid from non-NHS sources?*

There are no such plans at present.

13. *Is rationalisation of urban hospitals taking place in Northern Ireland? With what effect on research?*

In central Belfast there are two large teaching hospitals less than one mile apart: the Royal Victoria and the Belfast City Hospitals. It is perceived by the main purchaser and the DHSS that the capacity in these hospitals is excessive for the declining city centre population, that there is unnecessary duplication of facilities and that considerable savings can be brought about by rationalisation. About one year ago the Eastern Health and Social Services Board produced an acute strategy which suggested that the two hospitals should be managed by one Trust and that rationalisation should proceed from this. The University supported this view but it was rejected by the Minister for Health and Social Services. Instead a Steering Group has been

14 February 1995]

[Continued

established under the Executive Chairmanship of Dr James McKenna who stepped down from his position of Chief Medical Officer to undertake this role. This has representatives of the two Trusts, the Management Executive and the University, together with a GP fund holder and an independent member from England. The Steering Group has concluded that both hospitals will continue to provide acute services with the RVH specialising in trauma and the BCH in molecular medicine including oncology. Further detailed recommendations are awaited. It has also endorsed a project promoted by the two Trusts for the rationalisation of laboratory services.

It is difficult to predict the effect rationalisation might have on research. On the one hand it could have beneficial effects by concentrating resources on one or other site when at present they are divided. On the other hand, movement of specialties from one site to the other may have implications for academic departments associated with those specialties and no funds have been identified for the costs of movement of academic departments as a consequence of NHS rationalisation. The University hopes that its contribution to the rationalisation debate will result in departments with complementary research interests being close together and a better critical mass of researchers on each site. Thus rationalisation may produce unfortunate effects or might be helpful for research.

SUPPORT FOR CLINICAL ACADEMICS

14. *There is widespread concern in England about the career path for clinical academics. Is there similar concern in Northern Ireland? Is there much movement of clinical academics between Northern Ireland and other parts of the Kingdom?*

There is continuing concern about the career path for clinical academics. In recent years most appointments to Queen's University have been made from within Northern Ireland, although there have been successful applicants for senior appointments from outside. The University recruits clinical academics from the same pool as the NHS recruits consultants. There have been serious manpower constraints on the training grades in Northern Ireland for many years and thus the number of applicants for clinical academic posts has been very small, in some cases there has only been one applicant. One of the problems for clinical academics, not unique to Northern Ireland, is that they have to undertake both academic and clinical training and often try to prepare themselves for whichever type of post becomes available. In this way their research potential is often not fully utilised. Nevertheless, we are fortunate in Northern Ireland that it is the tradition that most of those in clinical training do undertake research and, while the motivation in some cases may have been initially career advancement, the experience may be the start of an important research career. For certain specialties there is a dearth of applicants for both academic and non academic posts at consultant level. There is some movement of clinical academics between Northern Ireland and other parts of the United Kingdom more usually at the level of Chair. Like other Universities we are concerned about the effects of the Calman proposals on academic medicine.

15. *To what extent is your medical school dependent on clinical academic posts funded by the Northern Ireland health service? What is the future of this funding?*

All clinical academic posts in Queen's University are joint appointment posts between the University and the Health Service. The Health Service component is now reimbursed to the Trusts under the STAR mechanism. There are only three posts which are fully funded by the Health Service. In comparing ourselves with Medical Schools elsewhere in the United Kingdom we find ourselves to be underfunded and seriously understaffed and it is our impression that we are seriously disadvantaged by lack of Health Service funded posts. It is, however, difficult to find exact data on this. Preliminary arrangements have been made for some members of the University to visit three comparable medical schools in England to try and obtain firm information on this.

16. *We gather that medical manpower planning in Northern Ireland is tightly controlled. Is this a good thing or a bad thing for academic medicine?*

Medical manpower has been tightly controlled in Northern Ireland for many years and the number of appointments to the Registrar and Senior Registrar grades has reflected predicted consultant opportunities. This has had serious and damaging effects on academic medicine, particularly for research. Much research is undertaken by young doctors in training. Lack of middle grade junior staff may also mean that senior clinical academics may have to spend more time on direct patient care with consequent loss of time for research. In many of the smaller specialties for many years there have been no young doctors in training and as a result there has been nobody to undertake research. This is less of a problem for larger departments.

14 February 1995]

[Continued

17. *How far does your medical school benefit from the DHSS Clinical Research Awards?*

The Medical School benefits greatly from the DHSS Clinical Research Awards. Most departments have clinical research fellows most years, and these very bright young doctors who are able to devote full-time attention to research are a major component of the research effort of the medical school. Unfortunately because of the training arrangements for hospital medicine many such doctors feel under pressure to devote only one year to research and it would be beneficial if they could spend more time and hence obtain better academic training. However, to increase the length of time would decrease the number of Fellows who could benefit. The research grants are also an important source of funding for medical school research.

18. *How far does your medical school benefit from the DHSS research studentships in dentistry, nursing, pharmacy and the therapies?*

The DHSS supplies 8 bursaries for MSc students in Nursing or Midwifery each year. These are taught courses with dissertations. The research for dissertations must be in respect of community or clinically related topics that are relevant to the management of health and social services or to delivery of nursing and midwifery care. The candidates also study research methods. There are no such studentships in Dentistry. The University has a School of Pharmacy but this is not part of the Faculty of Medicine and Queen's University does not teach the therapies.

Examination of witnesses

SIR GORDON BEVERIDGE, Vice-Chancellor, PROFESSOR ROBERT STOUT, Dean of the Faculty of Medicine, PROFESSOR ROY J MCCLELLAND, Director of the School of Clinical Medicine, PROFESSOR ELIZABETH R TRIMBLE, Assistant Director for Research in the School of Clinical Medicine, PROFESSOR ROBIN G SHANKS, Chairman of the University Research Committee, DR GEORGE BAIRD, Secretary to the Academic Council, and MR JAMES O'KANE, Bursar, the Queen's University of Belfast, were called in and examined at the University.

Chairman

636. Vice-Chancellor, thank you very much indeed for seeing us.

(*Sir Gordon Beveridge*) Thank you very much. On my left is Professor Roy McClelland, who is the Director of the School of Clinical Medicine and he is also the Professor of Mental Health. On my immediate right is Bob Stout, who is a Professor at the University and Provost and Dean of the Faculty of Medicine. On his right is Professor Liz Trimble, who is Professor of Clinical Biochemistry and she is the Assistant Director for Research in the School of Clinical Medicine. Further to my right is Mr James O'Kane, who is the Bursar of the University, and at the extreme end on the right is Dr George Baird, who is Secretary to the Academic Council. Then we have Professor Robin Shanks, Professor of Therapeutics and Pharmacology, who is a Pro-Vice-Chancellor and is also the Chairman of the University's Research Committee and a member of the Academic Planning Group. So we have two of the most senior administrators and we also have the key people from the Faculty of Medicine. Could I explain about the structure for a moment. We have the academic area of the University divided into five groupings which we call colleges, and we have a college that covers the whole of the medical area, health sciences, and Professor Stout is the Provost in charge of that. Then within that college and the Faculty of Medicine—and this is an anomalous relationship now—we have various schools and one of the schools is the School of Clinical Medicine that I mentioned earlier and that Professor McClelland looks after. So this is a fairly new development.

637. Thank you very much. Could we ask you to clarify the relationship then between the University, on the one hand, and the Royal Victoria Hospital

and the Belfast City Hospital, on the other? In particular, do any of the people who are with us today come from or work at the Belfast City Hospital or the RVH?

(*Professor Stout*) Yes. These are the two major teaching hospitals and the vast majority of the clinical academic staff have consultant appointments in these hospitals.

638. Both?

(*Professor Stout*) One or other. Professor Trimble is in the Royal Victoria Hospital and Professor Shanks, Professor McClelland and I are all in the Belfast City Hospital, although in fact the predominance of clinical academic staff is in the Royal Victoria Hospital.

639. And approximately what number of beds would there be in each of those two institutions?

(*Professor Stout*) The City Hospital has 600 beds, the Royal about 1,000, if you include the Royal Maternity Hospital and the Royal Belfast Hospital for Sick Children. It is a group of hospitals really.

Lord Perry of Walton

640. Are these hospital trusts now, as in the rest of the United Kingdom?

(*Professor Stout*) Yes, each is a separate hospital trust.

Chairman

641. And do the directors of the trusts include people from the University?

(*Professor Stout*) Yes, Dr Baird is a non-executive director of the Royal Victoria Hospital Trust and

14 February 1995]

SIR GORDON BEVERIDGE, PROF ROBERT STOUT,
 PROF ROY J MCCLELLAND, PROF ELIZABETH R TRIMBLE,
 PROF ROBIN G SHANKS, DR GEORGE BAIRD AND MR JAMES O'KANE

[Continued]

[Chairman contd.]

Professor Shanks is the same at the Belfast City Hospital Trust.

642. In some universities the Bursar is the person in charge of buildings and estates; in others, in charge of finance. Is the Bursar here in charge of one or other of those or both?

(Sir Gordon Beveridge) He is in charge of finance. We have a separate director looking after the estate.

Baroness McFarlane of Llandaff

643. May I ask about the Queen's University Health and Health Care Research Unit, what it does, what it covers and who pays for it?

(Professor Stout) This unit was established six years ago as a joint initiative between the Department of Health and Social Services and the University. Under the original contract it was funded with what was known as core funding from the Department of Health. It was intended that it should make contracts with other health service bodies to carry out research and the hope was that after five years it would become self-sufficient from contract income. It had a number of problems. First of all, it did not attract the contract income that was anticipated, I think probably mainly because the Health Boards decided they would do their own research rather than contract with this Unit; secondly, unfortunately we went through two Directors in the first five years and now have the third Director, but this is because the first two appointees were head-hunted, one to the London School of Hygiene and the other to the King's Fund, so that, of course, caused a lack of stability. We now have a new Director and we have a new contract with the Department of Health which gives us rolling funding from the Department of Health. So we have much more security of funding and we anticipate the Unit will now move forward in the way it was intended. It is intended to lead research in the delivery of health and social services particularly in Northern Ireland. There is a management Committee jointly between the University and the Department of Health and this receives reports from the Director and sets priorities. So within the strategy of the Department of Health it is intended to carry out research.

644. So that is within the strategies that were enumerated in the 1993 paper. Are those the strategies that are covered by this Unit? The other thing I am particularly interested in is what disciplines feed into that research?

(Professor Stout) It is closely associated with the University Department of Epidemiology and Public Health and our intention is that it should very closely relate to the other University academic departments. In other words, if it was going to carry out research in the delivery of maternity care it would link very closely with our Department of Obstetrics and Gynaecology. Currently the new director is in the process of recruiting core staff and these would include disciplines such as epidemiology, health economics, statistics and perhaps psychology. A lot of the people who work in that area come from psychology because they have training in survey methods and statistics, those sorts of disciplines. The Deputy Director is medically qualified, although the

post is currently vacant, and is usually seconded from the Public Health Medicine Department of one of the Health Boards.

Chairman

645. Roughly what size is the unit in terms of staffing and what is the annual budget?

(Professor Stout) In terms of staffing, when fully staffed the Unit would have about six permanent staff plus other research staff on short-term contracts, and the annual budget from the Department of Health is about £½ million. The University is now putting some money from its development funds into that Unit as well and is putting around £100,000 into it.

646. Perhaps we can then go on to ask you to highlight the activities and the objectives underlying the other two organisations that you identified, the Drug Utilisation Research Unit and the Cancer Registry?

(Professor Shanks) In 1966 the Department of Health in Northern Ireland took the initiative and introduced a system whereby, using computers, all the prescriptions written by general practitioners were recorded. This enabled my department to obtain records of all the prescriptions that were written by general practitioners and we were able to follow changes, for example, in the total number of prescriptions written for particular drugs, but we were also able to look at the changes or differences in the usage of drugs in different parts of Northern Ireland. For example, Professor Wade showed many years ago that there were differences in the way in which insulin was prescribed in Newry and in Derry, which are two medium-sized towns 80 or 90 miles apart, and the differences were due to the fact that in one there was a dietician attached to the Diabetic Clinic and in the other there was not. Since then the Department of Health has appointed a Medical Officer to visit general practitioners to give advice to general practitioners on the most appropriate prescribing and to see if they can rationalise the prescribing and in the end save money. Five years ago these two activities, one in my own department and one in the Department of Health, came together to form the Drug Utilisation Research Unit and it is funded by the Department of Health. The Medical Director is seconded from the Department of Health with time to work in the Unit. The other staff are paid for by a grant from the Department of Health. This has enabled us to bring together the two arms of Drug Utilisation, so that now, with considerable development of the databases, we have detailed information on all the prescriptions written by general practitioners in Northern Ireland. So we can get a printout every month of the prescriptions written by an individual practice. We can now follow changes in the prescribing within a practice of different drugs and we can also relate the prescribing of practices with the make-up of the patients. For example, we have an age/sex breakdown of all the patients in every practice, so we can find that in a practice with a large number of young children and a large number of elderly people their prescribing rates per member of that practice are much higher than if

14 February 1995]

SIR GORDON BEVERIDGE, PROF ROBERT STOUT,
 PROF ROY J MCCLELLAND, PROF ELIZABETH R TRIMBLE,
 PROF ROBIN G SHANKS, DR GEORGE BAIRD AND MR JAMES O'KANE

[Continued]

[Chairman *contd.*]

they are people with a smaller number of children and a smaller number of elderly people.

647. Have you any evidence that this policy has modified the prescribing habits of general practitioners?

(*Professor Shanks*) It did until about five years ago when the amount of time given by the Prescribing Officer in visiting general practices was reduced and the function was largely taken over by the four Boards, when they appointed a general practitioner to help give advice to general practitioners in modifying their prescribing. We can now provide information for each practice, not only on what they prescribe but on the way in which their prescribing could be improved and also made more economical; the problem now is trying to get medical advisers to visit the general practitioners, because, on the one hand, the representatives of the drug companies are encouraging them to prescribe the latest, most effective, most expensive drug; on the other hand, we have one person going around part-time trying to counteract that.

Lord Perry of Walton

648. It is all over the country that most general practitioners' first source of information is the drug companies' representatives.

(*Professor Shanks*) Yes.

Lord Butterfield

649. I know Wade very well and he, I believe, was very proud of this analysis. Is it matched anywhere else in the United Kingdom?

(*Professor Shanks*) Yes. It was set up in Belfast in 1966 and was established in the rest of the United Kingdom in 1988, so we had been running it for 22 years before it started in the United Kingdom. So it is now running in the rest of the United Kingdom by the Prescription Pricing Bureau, which is in Newcastle.

Chairman

650. Yes, it is. Do you have any policy relating to generic prescribing in the major hospitals?

(*Professor Shanks*) Yes. There are Drug and Therapeutics Committees in the hospitals and there is now a drug formulary for all the hospitals in Northern Ireland. It started off in one hospital but with junior staffs moving around the hospitals we felt it was important to have one formulary for all hospitals and the prescribing in hospitals has been rationalised. There is also a formulary produced by the Royal College of General Practitioners for use by GPs.

651. Who is going to tell us about the Cancer Registry?

(*Professor Stout*) It is the newest of these organisations. We have had various attempts at cancer registration over the years. There were cards left in doctors' surgeries which they were expected to complete and send in and, needless to say, the compliance was not particularly good. There have

been some independent cancer registries set up for particular cancers that people are interested in, but particularly with the health service reforms where purchasers are supposed to look at the health needs of their population, it was felt there was a need for a much better Cancer Registry. This again is a joint venture between the Department of Health and ourselves, partly funded by the Ulster Cancer Foundation, which is one of the large charitable organisations here which is very successful in fund-raising for this. It was set up about two years ago and the Director has been in post for most of the year. The Director came from public health medicine and has experience in cancer registration and she is currently setting up the systems and the computer facilities and recruiting staff.

652. And the Ulster Cancer Foundation would be comparable to the Cancer Research Campaign that exists in the United Kingdom, would it?

(*Professor Stout*) Yes, on a smaller scale, of course.

Lord Perry of Walton

653. I was very surprised to see from your own answer that you are only getting £83,000 altogether from the MRC, which is a drop in the bucket when they are spending £250-something million. I see you say that one of the reasons is that support is difficult to obtain, so that researchers become discouraged. Why should that be?

(*Professor Trimble*) It is difficult to analyse and come out with clear answers. I think there is already a feeling in people's minds of a barrier and many of us have experience which most people have elsewhere of alpha-rated projects not being funded, and because I think, on the other hand, within Northern Ireland we have perhaps clearer and easier access to funds at times to do work rather than wait for another eight or nine months' cycle to come round, we will go ahead with what funds we can get locally. This has been unfortunate from the point of view of the Research Assessment Exercise because the money that we get locally is not rated as highly. However, if we look at our output and the area where we are actually publishing our results, they are not significantly different from those people who are getting MRC money. So we would be very happy if the Research Assessment Exercise took on board mainly where we published and the quality of our publications. I think we would be happier with that than to have such a high rating being given to Council money. It is quite interesting that when we have looked at the things that have correlation with RAE outcome, they were not able to show, except in one group of health sciences, that there was a direct correlation between the amount of Council money obtained and the outcome. That was in one of three sections in laboratory medicine. In fact, there was not a correlation, in hospital-based clinical subjects, nor in epidemiology and community medicine, between the amount of money obtained from research councils and the outcomes which they looked at. I think the short answer is probably because it has up to now been easier for us to obtain charity money locally. The Northern Ireland people are very generous in their giving to major charities.

14 February 1995]

SIR GORDON BEVERIDGE, PROF ROBERT STOUT,
 PROF ROY J MCCLELLAND, PROF ELIZABETH R TRIMBLE,
 PROF ROBIN G SHANKS, DR GEORGE BAIRD AND MR JAMES O'KANE

[Continued]

[Lord Perry of Walton *contd.*]

654. Have you been worried by the fact that the Concordat provides guaranteed service support from the NHS for MRC-funded projects where it does not provide such a guarantee for the charitable ones?

(*Professor Trimble*) Absolutely, yes.

Lord Butterfield

655. When you are being assessed research-wise, do the assessors take into consideration any ratings you have from the MRC before you went elsewhere for funding?

(*Professor Trimble*) No.

(*Professor Stout*) Could I come back on the amount that is on the document. That is one year's funding. That is not research grants. So if the grant came in for three years it is divided into three for that figure. We are very much aware of the points you made about the Concordat, the fact that we do not get overheads from the charities and the fact that the charities do not pay for parts of staff that are used, and we are encouraging our staff to apply much more to the MRC. 1993 was the last year for which we had complete figures available. The figures for 1994 and 1995 in fact show a significant increase over this, so we are aware of this and we are working hard to improve it.

656. What is the total size of the clinically based staff in the two main teaching hospitals, what proportion are paid for by the University and what proportion are paid for by the NHS?

(*Professor McClelland*) There are just over 100 academic staff and they are partitioned into those who are clinical academics and those who are scientists. Approximately 70 of our staff are joint appointment staff, that is, half clinical and half University. These are clinicians who work half of their time with the health service, like myself, and, the funding for all but three comes half from the University and half from the health service. This is a historical anomaly which is unique, I think, to Northern Ireland. Then we have a much smaller number of full-time scientists, just over 30, and this indeed is one of our concerns and something we are trying to get clarification on. We have a belief, and I think it is not just based on suspicion, it is based on facts which we need clarification on, that our actual staffing size in the medical school is relatively small. This is of great concern in relation to the Research Assessment Exercise, where we know the volume factor is also becoming important as well as the quality rating.

Chairman

657. Is there any way, Vice-Chancellor, you could help us by comparing the £4 million approximate income on research grants and contracts for the medical faculty with what comes in to the other faculties from the other research councils, for example?

(*Mr O'Kane*) I think our total research over the year that these figures relate to, 1993-94, was £16.5 million and this figure is about 25 per cent of that. In relation to some of the sciences and engineering, a much larger percentage of the research income would

come from the research councils, particularly in relation to our two Grade 5 departments, Physics and Electrical Engineering.

658. I see that in the medical faculty there is relatively little coming from industry and very little indeed from the European Union. Do the other faculties fare any better in relation to European funding or industry funding?

(*Mr O'Kane*) I think again in essence the percentages coming from those sources would vary across the five colleges which the Vice-Chancellor referred to earlier. If we take again science and engineering, mainly the programmes which are on offer from the European Union tend to be more in the science and technology areas and obviously their percentages from those sources are reflected in that.

659. The enquiry that was undertaken by the Sub-Committee before we started to look at medical research was on international investment in United Kingdom science, where we found, for example, that most American and Japanese overseas investment in the EU came to the United Kingdom, which was a remarkable figure. Would it be your feeling that the political problems of the last few years may have been one of the reasons why there has been so little overseas investment in the Province?

(*Sir Gordon Beveridge*) I do not know about that. I am sure that the situation here has affected people but I am not sure that it has affected the flow of money, but if we look at it in a slightly different way, certainly visitors in the past 25 years have been quite often reluctant to come and some have never actually turned up. So in that sense our research workers are not so well-known and it may also, due to the fact that we are on an island off an island, have restricted the movements of our own staff across in Great Britain and other fields. So certainly the troubles have had some effect but whether this is preventing investment here or not I do not know. I think it is more to do with people and the awareness of what has happened.

Lord Perry of Walton

660. The new NHS structure, reducing the number of registrar posts and increasing the number of consultants, has meant in Edinburgh, for instance, they are facing reducing the number of lecturers from 46 to 16. Does your dual support system avoid this?

(*Professor Stout*) I do not know that it does. We in Northern Ireland have had very strict manpower policies applied to junior medical staff for quite a large number of years. Each year we are told by the Department of Health in negotiation with the profession the number of new appointments to the registrar and senior registrar grades and this is very closely matched to the predicted consultant opportunities in Northern Ireland. So we have really gone through this process already and it certainly causes us considerable difficulties.

14 February 1995]

SIR GORDON BEVERIDGE, PROF ROBERT STOUT,
 PROF ROY J MCCLELLAND, PROF ELIZABETH R TRIMBLE,
 PROF ROBIN G SHANKS, DR GEORGE BAIRD AND MR JAMES O'KANE

[Continued]

Chairman

661. Would you like to say something about the extent of collaboration in the funding and conduct of medical research between Northern Ireland and the rest of the United Kingdom or of contacts with the Republic?

(*Sir Gordon Beveridge*) Would it be possible to keep going with your previous question for a moment or two? In the reply we state that we are endeavouring to change the situation whereby we are perhaps not getting sufficient money from the MRC and other bodies. We have set up in the University quite recently the University Research Committee, which Professor Shanks chairs, and perhaps Professor Shanks could come in and tell you a little bit about how he and his colleagues are now starting on a very positive process of encouraging academic researchers to seek out money.

662. It would be helpful, thank you.

(*Professor Shanks*) In the past, and it was probably the same in many universities until recently, research was funded bottom up and not top down and we are now changing from the bottom up to the top down, so that we have a Research Management Unit that brings the academic area, the financial area and the industry links all together with a group of three people with support staff underneath and I am the Director of that Unit. We also have a Research Committee composed of representatives from different areas of the University and that Research Committee is now meeting with the directors and heads of all the research units within the University, that is, all the centres that are going to be assessed in the next Research Assessment Exercise, and we are asking them the type of questions you are asking us about the number of publications, research grant income, applications for research grant income, income from industry, and then comparing them with the figures we have for the average United Kingdom university and for our comparator universities across the water. This is a change for Northern Ireland but it has been very well received and we are currently having presentations by all the units to try to ensure that they are well organised and well prepared for their submissions to the next Research Assessment Exercise in 1996. By bringing together the administrative staff involved in research we are now able to pick up all the opportunities that are arising elsewhere and then identifying staff within the University to whom that information should be sent and then having discussions with them and asking, "If we send you information about these opportunities, why are you not making use of it?"

Lord Perry of Walton

663. Has there been a Higher Education Funding Council for Northern Ireland survey here as there have been in Scotland and England?

(*Professor Shanks*) Under the Research Assessment Exercise?

664. Yes?

(*Professor Shanks*) Yes. We are assessed on exactly the same lines and same regulations and rules as all the other universities across the water.

Chairman

665. If I can follow up the point you made about the Research Committee, I have an association, of course, with my former university which established a Research Committee like this some years ago, not only to identify further sources of funds and to identify the bright rising stars, but they took a positive decision, which I am not sure has been followed by other universities, to top-slice the budget of the university as a whole and provide that Committee with a budget to which individual members of the university could apply for research support and grants. Is this something you have contemplated doing?

(*Professor Shanks*) Yes, we in fact have done that because the Department of Education in Northern Ireland created a special fund, the Northern Ireland Development Research Fund, and the distribution of that is determined by the Research Committee and the Research Group and we have been looking for areas within the University that we wish to maintain but also looking for the new areas that are going and the new staff that are coming who we think will contribute to improving research. This fund is allocated using well laid out strategies and we monitor very closely the way in which the funds have been used. For example, if funding is allocated for a particular post, we follow the advertisements, the interviews, the appointments and we know exactly when the person is in post and what they are going to do in a way that has never happened before.

666. That is very helpful. One message we continually receive in this enquiry from clinicians in particular is that they are being increasingly pressed by managers to increase their clinical throughput of patients and this is impairing their ability to conduct research because of pressure on time.

(*Sir Gordon Beveridge*) This is an important point, my Lord Chairman. The clinical load carried by our staff in the University and in the health service is a 50 per cent balance and certainly as far as funding is concerned the heavy clinical load tends to dominate, for the reasons we have indicated, and therefore what suffers is research.

Lord Butterfield

667. I was hoping when I heard I was coming here that I would see Professor Love because he has worked and helped me in London with the Health Promotion Research Trust. I notice that the logo of your Department of Health includes in its circle of all-embracing activities health promotion and I wondered whether that came into your thoughts at all or whether the epidemiologists were going to do surveys of health behaviour and so on. We know there is some very good Europe-stimulated health promotion going on in Northern Ireland and I wondered whether it was a topic that interested people. Of course, doctors are rather worried about it because it might turn off patients and, therefore, alter budgets, but I think the people are quite interested.

(*Professor Stout*) I think that is a little bit in the future. The Health Promotion Agency for Northern Ireland, which is an agency of the Department of Health, funds an academic appointment in the University on cardiovascular epidemiology. That is

14 February 1995]

SIR GORDON BEVERIDGE, PROF ROBERT STOUT,
 PROF ROY J MCCLELLAND, PROF ELIZABETH R TRIMBLE,
 PROF ROBIN G SHANKS, DR GEORGE BAIRD AND MR JAMES O'KANE

[Continued]

[Lord Butterfield *contd.*]

in the Department of Epidemiology and is held by an epidemiologist who came from Cardiff. So there is that particular post and the Department of Epidemiology and Public Health would be the area that is most responsible for this and for teaching this area. But our University Department of General Practice is also very closely involved with health promotion and has carried out a number of studies recently on the effectiveness of health promotion, particularly the effectiveness of giving advice to people which turns out not to be very effective.

668. You did some marvellous work on diet and coronary heart disease, with which I am familiar and which I greatly admire.

(*Professor Stout*) Yes. So there is quite an interest in health promotion and it is an area where we will be putting increasing emphasis, particularly as we redesign our undergraduate curriculum, because it is going to have a much higher profile there.

Chairman

669. In relation to R&D your memorandum said: "It is essential that a Research and Development Strategy for Northern Ireland and the post of Director of HPSS Research and Development is introduced as soon as possible." There was a consultative document issued almost two years ago, April 1993, and yet no action appears to have been taken to appoint such an individual. Would you like to comment on the importance of that post as you see it?

(*Professor Stout*) We are very concerned at this delay. We strongly support the appointment of a Director of R&D for Northern Ireland. We feel we are falling further and further behind the rest of the United Kingdom in this area. There is government money which goes into R&D in various forms but it is not well directed and there is no policy on this area. We have been pressing the Department very hard for such an appointment. Clearly if a Culyer-type policy is introduced in Northern Ireland, there must be a Director of R&D and we would like to see that person in post as soon as possible to start getting the policies under way.

670. Would you prefer that Northern Ireland should be part of the priority-setting processes for the whole NHS R&D Strategy, with representation, as you suggest, on the Central Research and Development Committee and lead responsibility for particular areas of research, or would you prefer that Northern Ireland has in a sense to go it alone?

(*Professor Stout*) Our view would be that we should be a lead region for a particular part of the R&D Strategy. Northern Ireland is much smaller than any English health region with only 1.5 million people. The budget for R&D is going to be correspondingly small. I think for Northern Ireland to try and cover the whole range of R&D would not be an effective means of using the budget and we would much prefer to be a lead area for a relevant subject. The one that we suggest in this document is community care. Because of our unique integrated health and social services we feel there are opportunities here for exploring care in the community and, of course, the interaction between

care in the community and hospital care, in a way that is not possible in other systems, and we would like to be represented on the Central Committee as well.

Lord Butterfield

671. One of the things we worry about very much, and especially with the good educational base that you have in this country, is taking care of the bright young people and making sure they get into what I call hard research. I do not mean by that some is soft but it is interesting that there are some subjects which are just seen to be well beyond the range of a lot of people in medicine and we do not want to lose the people who can master the intricacies of renal function or whatever. One of the problems that your proposals inevitably perhaps will create is a push towards paper research rather than laboratory research. I just hope, Vice-Chancellor, somehow or other you will be able to track down those bright young people and make sure they get up to the top of the tree. It is a difficult problem and I quite agree that your integration of social services and medical care is a terrific opportunity to show the rest of the country what to do. So I do not want to stop that but I feel that there is the risk that there will be a shortage of opportunities for the bright men. So maybe somebody has to provide you with some research studentships or whatever.

(*Professor Stout*) My understanding is that the NHS R&D Strategy is only one component of the whole research area of the University or the medical school and it is not in any way supposed to detract from the laboratory-based sciences. We would entirely agree with you and we see the two as complementary.

Chairman

672. But the very proper concentration on so-called health services research, looking at patient outcomes, epidemiology and so on, may have in some respects detracted from the concentration on biomedical research, curiosity-driven research, in the hospital sector. Have you any evidence that the R&D activities of the four Health Boards have had such an effect in Northern Ireland?

(*Professor Stout*) The R&D activities of the Health Boards here have really been on quite a minor scale, so they would not have the scope for detracting from that, and, of course, without having an R&D Strategy for Northern Ireland as yet, we cannot really address this question. But we certainly have no shortage of bright young doctors, the competition for entry into our medical school is extremely high and there is no shortage of bright young doctors waiting to enter biomedical research. Professor Trimble is a leading person in this area and I am sure she would agree with that.

(*Professor Trimble*) Yes, I think we have. I think what is most deflecting for these people in the health service today is to know what they are getting themselves ready for and there are not many of them who are so psychologically tough as to say, "I don't care whether I get a job in academia at the end."

14 February 1995]

SIR GORDON BEVERIDGE, PROF ROBERT STOUT,
 PROF ROY J MCCLELLAND, PROF ELIZABETH R TRIMBLE,
 PROF ROBIN G SHANKS, DR GEORGE BAIRD AND MR JAMES O'KANE

[Continued]

[Chairman *contd.*]

Most of them have dependents and mortgages and they have to equip themselves for whatever job comes up and they really would be rather silly if they did not. I have worked abroad for many years and I know what I am comparing with and we have some first-class people here.

673. Where did you work abroad?

(*Professor Trimble*) I worked with a diabetes group for about eleven years in the University of Geneva.

Lord Perry of Walton

674. We certainly also have very bright young people applying to Scottish universities. We know only too well.

(*Professor Trimble*) Those are the ones who slip through our net!

675. I would like to emphasise what our Chairman said. I was on the Committee when we recommended the creation of the Peckham situation, so I find it very ironic that I am now fighting in part against the concentration of expenditure on health services research, which was terribly badly needed and still is but it is not needed at the expense of biomedical research.

(*Professor Trimble*) Can I stress that what I have just said is a real thing. Whether I am talking to my colleagues on the mainland or here, the folk who are at senior registrar level, who are extremely bright, are also extremely worried and they think that they will get themselves down a cul-de-sac where, if they go for a job in a DGH, they are not seen to be relevant because they have not had the relevant experience. They keep themselves going on both channels and it seems the only way forward in this period of enormous change.

Chairman

676. Professor Shanks, was there something you wanted to add?

(*Professor Shanks*) It has been largely covered, my Lord Chairman, but Lord Butterfield made a very important point. The manpower planning here has been very tight in recent years. Ten years ago I had four senior registrars and they were all as bright as the people Liz Trimble has described, and now we have one and that one person spends most of her time carrying out clinical medicine and doing no research, and my Department—I have been there quite a long time—has suffered considerably and I think this applies to all the other clinical academic departments. We do not have the young lecturers we had in the past.

677. One major contribution, of course, has been made by the Wellcome Senior Clinical Research Fellowships and also by the Wellcome Senior Lecturer Scheme and, who knows, this may well be expanded with the increased funding from the Wellcome Trust. Have you been successful in attracting any such appointments here in Northern Ireland?

(*Professor Shanks*) We have occasionally, but again it comes back to the point that Professor Trimble made. Clinical Academic staff, clinical staff,

senior registrars, are concerned that if they get into such a post, where will it lead to in the end? They may be okay for five years, but ten or 15 years and they tend to move out into the National Health Service.

678. That is an issue about which we are very concerned.

(*Professor Stout*) Could I say we did, in fact, gain a Wellcome Senior Lecturer in Ophthalmology last year.

679. And if it were again likely that the same kind of thing happened as happened when Northwick Park Clinical Research Centre was broken up and units were, as it were, disseminated, is it likely that you would be thinking about applying from time to time if you could identify an appropriate area or an appropriate individual to take on such an MRC unit?

(*Professor Trimble*) Absolutely.

(*Professor Stout*) We have never had an MRC unit here.

680. No. It is an ambition?

(*Professor Stout*) It certainly would be an ambition. I do not think we were offered anything from Northwick Park.

681. No, but sometimes it required a certain pressure to say, "We have X, Y and Z who could really handle this," and let us see if you can bring them here.

(*Professor Trimble*) The same thing is happening with Bart's at the moment, as you probably well know.

Baroness McFarlane of Llandaff

682. My understanding is that the National Board for Nursing, Health Visiting and Midwifery does not have a strategy but it has a budget of roughly £10,000 per annum. I wondered if any of that came to you or is it seen wholly as an education research budget? Does any of that come into your Province, the Action Plan for Nursing Research Development of the Department?

(*Professor Stout*) As you are aware, our academic nursing is really quite recent here and, of course, the major emphasis is on education and we are moving towards integration of nursing education with the University later this year, so research has a rather lower priority in nursing at present, I am afraid. I do not think any of this £10,000 comes to us as research grants. I asked Professor Orr about this and she felt there was not a National Board strategy here. Eight studentships per year come into our school of nursing and these support nurses who are on essentially taught master's courses. There is a dissertation element to these courses, which is largely in community nursing, but they are taught masters rather than research fellowships.

683. I see.

(*Professor Stout*) Yes.

684. Is there any plan to build up the nursing and allied health professions research or is it largely still a medical bias?

(*Professor Stout*) It is a medical bias because of the balance of numbers at present. The numbers will change very rapidly when we acquire 70 nurse

14 February 1995]

SIR GORDON BEVERIDGE, PROF ROBERT STOUT,
 PROF ROY J MCCLELLAND, PROF ELIZABETH R TRIMBLE,
 PROF ROBIN G SHANKS, DR GEORGE BAIRD AND MR JAMES O'KANE

[Continued]

[Baroness McFarlane of Llandaff *contd.*]

teachers later this year. The problem is that these nurse teachers will come from colleges where there has been no tradition of research and this is one of our major worries about the integration process.

685. I wonder if you are developing a strategy on that front?

(*Professor Stout*) What we would like to do is to be able to have some posts free where we could go out and recruit the best possible academics into these nursing posts, and this is an area we are arguing with the Department at the moment. I suspect the way things are going we may not be able to do so but certainly as far as the other appointments that have been made to the school of nursing are concerned, there has been a strong research emphasis. Last year, as part of the manpower planning in the colleges of nursing, we were offered six posts. They transferred money to the University for six lectureships on condition that we appointed from within the colleges. We only appointed four people to these posts because we could not obtain six who had the necessary academic background. So in any post over which we have control we are determined we are going to get people who are going to do research.

Chairman

686. Is it likely that you will be able to identify funds that might be able to support research studentships for people in nursing who could read not just for Master's degrees but for PhDs?

(*Professor Stout*) We would hope so and perhaps as part of an R&D Strategy, if it comes in, we would be able to do so. There are awards currently from the Department of Health which have no disciplinary restriction on them, so there is no reason why they should not be awarded to nurses if good projects go forward. The other area, of course, that is important is that since nursing is part of the University, we have joint projects with other areas of the University between medicine and others and this is an area we are moving forward on, too.

687. Just to follow up your interest in community care, one issue which has been put to us is that a number of general practices have been identified as research general practices where supplementary funding has been provided, for example, by the Royal College of General Practitioners, and in other circumstances general practitioners have been offered funded research sessions to help them to engage in research. Is that the kind of initiative you hope to see followed in the Province?

(*Professor Stout*) We would certainly like to see it here, yes. We have a very high standard of general practice here, a lot of health centres and very enthusiastic general practice teachers, and I think to encourage further research here would be very useful.

Lord Perry of Walton

688. I am moving back to STAR. In Scotland, which is different from England and that is why I am using it as an example, the distribution of the teaching element is settled by the Dean and Chief Executive Officer of the hospital trust together and

distributed to departments according to teaching load. Is that the same with you?

(*Professor Stout*) Yes.

689. If the 'R' component has to be settled not in terms of student numbers and teaching load but in terms of research assessment, are you happy with the suggestion which is tentatively made by Culyer that it should be by a joint assessment with the HEFC?

(*Professor Stout*) Yes. I think it would be an enormous burden on all of us if we had a separate assessment for health service research. We would certainly feel it ought to be part of the same assessment.

Chairman

690. Have you any links with the Cochrane Centre, the York Centre for Reviews and Dissemination and the Leeds Clearing House on Health Outcomes?

(*Professor Stout*) No direct links, no.

691. None at all?

(*Professor Stout*) No.

692. Is that something you may hope to build on?

(*Professor Stout*) I think so. I think Professor Trimble has a colleague who has some personal links here. Dr Chalmers was here a few months ago to talk to us.

Lord Perry of Walton

693. I think everybody agrees that the dissemination of research and clinical trial information to providers is absolutely splendid. Do you have any fear that dissemination to purchasers might lead to interference with clinical freedom of treatment?

(*Professor McClelland*) I am sure we are in an area where we have to look at cost-effectiveness and I think it comes back to something Professor Shanks was referring to, the initiative to encourage GPs to look at the most cost-effective way of managing practices. One would hope within the output from audit one would see from the clinical end a move in the same direction and we hope to see commonsense prevailing in clinical practice in terms of the best and most cost-effective way. If we do not do it we are just moving money from one part of the health service to another. Good practice is something that clinicians are interested in, in both the hospital and community sectors. In my own area (mental health services) we want to try and pursue this through the colleges particularly and postgraduate councils. We need to move increasingly to good practice management, good modes of practice, but not to strict protocols—that is perhaps the extreme position—but to broad guidelines on good practice.

694. Referring to the example we used before, it would be cheaper to do dialysis than to do a transplant obviously from the purchaser's point of view. There would never have been transplants, which are now cheaper, if the purchaser had had control?

(*Professor McClelland*) I think you are highlighting an important concern that many

14 February 1995]

SIR GORDON BEVERIDGE, PROF ROBERT STOUT,
 PROF ROY J MCCLELLAND, PROF ELIZABETH R TRIMBLE,
 PROF ROBIN G SHANKS, DR GEORGE BAIRD AND MR JAMES O'KANE

[Continued]

[Lord Perry of Walton *contd.*]

academics would have and that is the short-termism that goes into the market-driven approach to health care management. That must be moderated to be a more long-term investment and I think R&D sits very comfortably in that.

Chairman

695. It implies that infrastructure support for biomedical research, facilities for such research, must be one of the important protected components of the 'R' stream. Arising out of what has been asked, one thing that surprised and I would think concerned us somewhat is that we have noticed certain units being funded in Britain from the R&D budget of the Department, where the contract with a particular unit has required that prior to publication the Secretary of State's permission has to be obtained. Are you familiar with any such requirement being imposed upon you by the Northern Ireland Office?

(*Professor Stout*) I have a research contract with the Department of Health which certainly indicates that I should get permission from the Department before I publish the results.

696. Is this something you would find acceptable?
 (*Professor Stout*) No.

697. The prospect of every single paper on all biomedical and other forms of research supported from departmental funds having to go to the Department of Health strikes me as incredible.

(*Professor Trimble*) It is like anything else about competition. It means your competitive edge has gone because American colleagues will do it before you can get it through your processing.

698. That is a matter of concern. I am glad you share our concern. It follows from what Professor Stout was saying that one of the casualties of the purchaser/provider system in the National Health Service has been extra-contractual and tertiary referrals to centres of excellence and you mentioned this in your memorandum. Is this something that is beginning to emerge in Northern Ireland?

(*Professor Stout*) We are one year behind the rest of the United Kingdom in the implementation of the health service reforms, so what may be appearing across the water may not appear here yet. I myself am not aware of this being a problem but I can see it as being a potential problem and I can see, for example, that perhaps for some of the more common diseases which used to come to hospitals and which could form the basis of a large amount of clinical research and clinical trials, GP fund-holders may not wish to refer them to hospital any more, but I am not aware of any problem at this point. I do not know if any of my colleagues can tell you.

699. So in cases of rare diseases as well as common diseases the consultants in the peripheral hospitals are not treating them but are referring them to the specialist units where the trials of new treatments are being conducted?

(*Professor McClelland*) There is a policy within Northern Ireland that there is a regional consortium that purchases services for certain diseases and there has recently been a contract awarded for the treatment of adults with cystic fibrosis and rather

than being sent to various hospitals in Northern Ireland there is a contract for all these patients in Northern Ireland with one unit at the Belfast City Hospital so that the tertiary referrals are all to one place.

700. Thank you, that is an interesting and important point.

(*Professor Trimble*) Sadly, I think a few cases of litigation will probably solve the problem and the pendulum will probably swing back, if they are not being treated adequately in the hospitals where there is an insufficient throughput for staff to get enough expertise and things go wrong, but that will take a few years.

701. That is one issue and the other is that in trials of new treatment one must have access to an adequate number of people suffering from the condition in order to be able to mount a proper trial. Are there any plans to set up research beds? We have learnt that on smoking, for example, certain commercial organisations have funded, and charities have funded, the actual revenue costs of beds that have been identified as being designated for research purposes? Are you familiar with anything like that happening here?

(*Professor Stout*) No.

Lord Perry of Walton

702. Would you welcome it if you got such an offer?

(*Professor Stout*) I do not think we would turn down any offers that came. We would certainly discuss it with them.

Chairman

703. Would you even be interested in the possibility that if the infrastructure funding coming from the 'R' component of STAR were to be identified as being sufficient to cover an occasional research bed or a contracted out-patient session, for example, for research purposes—would you be interested in the possibility of using such funds for this?

(*Professor Stout*) Yes, indeed, I think that would be very important.

704. Are you suffering from any proposed rationalisation of urban hospitals such as we know is happening in various other parts of the United Kingdom?

(*Professor Stout*) As we mentioned earlier, there are two major teaching hospitals in Belfast, the Royal Victoria and the Belfast City Hospitals, which are about one mile apart. The powers-that-be took the view that there is unnecessary duplication of services within the city centre hospitals. The population they serve is diminishing and moving out to the periphery and probably referral patterns will change and services will not be required. The Eastern Health and Social Services Board, which is the major purchaser in this part of Northern Ireland, suggested the two hospitals should become one trust and rationalised in this way. The Minister for Health did not accept that view and a Steering Group has been

14 February 1995]

SIR GORDON BEVERIDGE, PROF ROBERT STOUT,
 PROF ROY J MCCLELLAND, PROF ELIZABETH R TRIMBLE,
 PROF ROBIN G SHANKS, DR GEORGE BAIRD AND MR JAMES O'KANE

[Continued]

[Chairman *contd.*]

appointed under the chairmanship of Dr James McKenna, who stepped down from his post as Chief Medical Officer to chair this as Executive Chairman, and this group contains representatives of the two trusts, the Department of Health, the University, a GP fund-holder and an independent health economist from England. It is working fairly slowly on this rationalisation exercise. I am the University representative on the Steering Group. It is difficult to predict what the outcome is going to be. At present there are working parties on each of the specialties and they have yet to report.

Lord Perry of Walton

705. You have an accident and emergency service in both?

(*Professor Stout*) Yes.

706. And they are only a mile apart?

(*Professor Stout*) Yes.

(*Professor Shanks*) We should also explain that another mile away from the Royal Victoria Hospital is the Mater Hospital, which has recently had a lot of money spent on providing new accommodation and it has an A&E Department, and about four or five miles away to the east of Belfast there is another hospital, the Ulster, with an A&E Department. We are in a way 15 or 16 years behind what is happening in London in that we still have small hospitals in many small towns in Northern Ireland. We have nine or ten obstetric units.

(*Professor Stout*) We have 26 acute units.

707. For a population of 1.5 million?

(*Professor Shanks*) You might ask about that rather than rationalisation between the Royal and the City.

708. We feel one of the other potential problems when the regions disappear is that the benefits of regional training for and control of individual trusts will potentially disappear, so that there might be nothing to stop uncontrolled growth of super-specialties in hospitals seeking to bring in more income, as has happened in certain parts of the United States, where every 150-bed hospital has its own neurosurgeon.

(*Professor Shanks*) We see signs of that in Northern Ireland. The new trusts are advertising for large numbers of posts, including specialist posts, not neurosurgeons but people who we feel would be much better concentrated. The management executive says they will not touch a regional strategy.

Lord Butterfield

709. Can I go a little further with this question of A&E. I am involved with the Guy's/St Thomas' merger which is going perhaps, we hope, to take place with King's College in the Strand. It is quite clear that there is going to be a very strong move to close the accident and emergency services at one of those two hospitals. I am very strongly of the opinion that the hospital that has not got A&E should concentrate on admitting cases, that they are not likely to need A&E as a result of what surgeons and other people do to those cases. Do you see the possibility of that kind of

rationalisation in the future here? I am sure we cannot actually run A&Es as we used to where they were in effect general practices for people at night. We want better general practices than that but I can quite see that we do not want to make all of them too close together, but if you take an A&E department away from a hospital that has not been melded with another hospital on a rational basis, you run the risk of practically destroying the recruiting potential of that hospital for new doctors who feel it is going to be a cottage hospital.

(*Professor Shanks*) The proposals that have come out so far about the Royal and the City Hospitals are that both will remain as general hospitals, although the Royal will become the major trauma centre whereas the City will concentrate on molecular medicine and oncology. I think the problem, of course, as you will know, is that for general medicine most of the admissions come through the A&E, so if you close an A&E Department that would have a major effect on the clinical profile of the hospital.

Chairman

710. And, of course, equally, to have a fully comprehensive accident service taking up accidents and emergencies you need general surgery, plastic surgery, neurosurgery, cardiothoracic and orthopaedic surgery and it becomes extremely difficult?

(*Professor Stout*) All these specialties are at the Royal Victoria Hospital and that is why it is to become the major trauma centre, so to some extent we distinguish between trauma and the other run-of-the-mill A&E.

711. Can we then come to the issue about which you have already expressed serious concern, that is, clinical academic medicine. You have already made it clear you have anxieties about this. Is there at present much movement of clinical academics between Northern Ireland and other parts of the United Kingdom? Are you able now to recruit from other parts of the United Kingdom and vice-versa?

(*Professor Stout*) We do get applicants for chairs. We do not get many applicants for senior lectureships, at least not in recent years. I would have thought the net flow is from out of Northern Ireland rather than inwards.

712. For many years?

(*Professor Stout*) Yes.

713. You have had for many years the so-called A plus B system of joint appointments between the University and the health service, but one major development in the last few years has been that the regional health authorities have to an increasing extent been paying the whole cost of establishing chairs and other appointments, particularly in specialties which they see as being in need of academic development. Have you any such appointments in Northern Ireland which are wholly funded by the health service but established in the University?

(*Professor Stout*) Of the 70 members of staff that Professor McClelland mentioned a few minutes ago, we have three fully funded by the health service.

14 February 1995]

SIR GORDON BEVERIDGE, PROF ROBERT STOUT,
 PROF ROY J MCCLELLAND, PROF ELIZABETH R TRIMBLE,
 PROF ROBIN G SHANKS, DR GEORGE BAIRD AND MR JAMES O'KANE

[Continued]

[Chairman contd.]

714. In what disciplines?

(*Professor Stout*) One was Professor Trimble in Clinical Biochemistry, one is a Reader in Psychopharmacology and one a Senior Lecturer in Medicine, but the latter are more of a deal done as a strategy on the part of the health authority. It was only Professor Trimble's post that they decided would be an academic rather than a health service post.

715. Does the University offer personal chairs to people employed whole-time by the health service?

(*Professor Stout*) Yes, honorary chairs.

716. My old friend Ingrid Allen, is hers an honorary post?

(*Professor Stout*) No, she is a joint appointee.

717. You have already told us about the medical manpower planning. Do you have any interesting solutions that you can offer relating to how we can improve the recruitment and incentives for recruitment to academic medicine?

(*Professor Stout*) One of the things, of course, we have not yet seen is the academic report from the Calman Group. We do not know how it is going to come out and we do not know how they foresee people doing significant research during their training as distinct from getting experience away from research. I do not really have an answer. I do not know whether any of my colleagues has an answer at the moment. I suspect that what we have to do, and I would hope it happens if we are going to move more towards a consultant-run service and, therefore, are going to increase the number of consultants needed, is that some of those will be in academic departments and presumably funded by the health service.

718. Have you any comments on the Kendall Report on the future Distinction Award scheme? It has been suggested to us that one major disincentive to recruitment to academic medicine is because of the increasing concentration on giving C awards for service to the NHS as a whole, but it has been very few academics who have got on to the first stage of the ladder.

(*Professor Stout*) I do not think that is a problem in Northern Ireland, but I certainly have heard it said to me by some of my clinical academic colleagues, "I will work harder in the health service because that is where I am going to get my Distinction Award, not from the University." That is certainly something in the back of people's minds.

(*Professor Shanks*) I am a member of the Distinction Awards Committee for Northern Ireland. The impression I have—and I do not have the exact figures—is that clinical academic staff generally do better than full-time National Health Service staff. Whether that will change I do not know but in the past, if you take the Senior A and A plus award holders, the majority of them are academic.

719. I think that is wholly accepted in England and I think, Lord Perry, in Scotland. The problem has been to get on to the first step, to get the C, and once they do, the academics tend to rise more rapidly, but it is getting on to the ladder that has been the problem?

(*Professor Shanks*) I have only been a member of the Committee for a year but my impression looking at the claims is that the academic staff have no problem getting on to the ladder.

(*Professor McClelland*) Perhaps I can take you back to the last point in relation to incentives for academics. One key point is the availability of posts. We have already pointed out the fact that the NHS in England has wholly funded a number of University appointments. You may wish to ask the Department about it this afternoon. I think historically because we have had a high input from the University our health region has not had to address the under-provision in the NHS and I think that is quite crucial. The problem is now in the context of the RAE which is important in relation to the University profile and its quality assessment. We are now significantly disadvantaged and while I think there is a perception centrally that health services in Northern Ireland may be over-funded, it may have been because to some extent the distribution of these funds is very different. I suspect that the University on its health service interface has done rather badly and we were rather weak in that area. The University has had to put more funding support into that sector at the cost of not having more full-time scientists. I think that is the problem.

720. Has the University over the last 12 to 15 years been compelled to freeze posts, academic vacancies, in clinical medicine to make savings?

(*Professor Shanks*) Five or six years ago when I was Dean of the Department of Medicine we had to get rid of a large number of lecturer posts to the National Health Service and we have been freezing posts ever since.

(*Professor Stout*) And we are going through it again now.

721. Have you any evidence whatever as to just how many academic posts you may have lost in clinical medicine over the last 15 years? It would be very helpful.

(*Sir Gordon Beveridge*) Could we send it to you?

722. Please.

(*Professor Stout*) Can I get back to the question of incentives for academic medicine. What I see as more of a threat than Distinction Awards is the possibility of local pay bargaining, because while there is parity of salary between the health service and the University, I think we are at least on a level playing field but if we lose that I can see a major problem.

723. That has been brought to our attention from other sources and one of the other disincentives is the potential rewards in the financial sense for NHS consultants being able to engage in limited private work. Do you allow limited private work to your academics in clinical medicine?

(*Professor Stout*) Yes, we allow the same arrangements as for full-time consultants.

(*Professor Shanks*) But there is not that much private work in Northern Ireland. The two specialties where it is significant are orthopaedics and obstetrics and gynaecology, and those are two specialties where we have difficulty obtaining staff. They will take academic posts for a few years until a National

14 February 1995]

SIR GORDON BEVERIDGE, PROF ROBERT STOUT,
 PROF ROY J MCCLELLAND, PROF ELIZABETH R TRIMBLE,
 PROF ROBIN G SHANKS, DR GEORGE BAIRD AND MR JAMES O'KANE

[Continued]

[Chairman *contd.*]

Health Service consultant becomes available and they will be appointed to that.

(*Professor Stout*) If we are talking about incentives, if people are looking for an academic career what they are wanting to have is the support and facilities to carry out their academic activities—good laboratories, staff, technicians, research assistants and so on. I think for many people who are keen on an academic life the lack of private practice is not a factor in their thinking, but when there is also in contraction in University support there is a great problem.

724. I agree, and the other disincentive is the much more generous terms which the NHS can offer over issues such as resettlement, giving such generous travel and removal expenses and solicitors' fees for the purchase of houses and so on, which the University is not usually able to do, but it may be different here?

(*Sir Gordon Beveridge*) We do offer a relocation package.

725. Comparable to that in the health service?

(*Sir Gordon Beveridge*) That I do not know about. We can tell you about the academic ones but I am not sure about the clinical side.

(*Mr O'Kane*) It would be regarded as a fairly generous relocation package. I do not know the direct comparison with the NHS.

Lord Butterfield

726. I was wondering whether they benefit through research studentships in dentistry, nursing, pharmacy and the therapies?

(*Professor Stout*) The nursing one I have dealt with already. They are a few taught masters. The dentistry one we are not aware of unless they are for dental hygienists, but dentists compete in the same way as doctors for the research studentships. We do not have the therapies here; they are at the University of Ulster.

Chairman

727. You have stressed the extent to which you benefit from the DHSS Clinical Research Awards, most departments having Clinical Research Fellows.

(*Professor Stout*) Yes, indeed.

728. That is very important, clearly. Is there anything you would like to add which you feel we may not have covered in this morning's discussion?

(*Sir Gordon Beveridge*) Yes, I think there are three points we want to come back on and touch on. One is STAR, the second is the medical library and the third is the volume of our medical staff.

(*Professor Stout*) STAR started off as comparable to SIFTR in England with the same unit cost per clinical student. In Northern Ireland, unlike the remainder of the United Kingdom, efficiency savings have been applied to these, so as a percentage taken off each year, the amount of money, is shrinking. So that is an issue we are concerned about. As you know, STAR has been uplifted in England by £40 million in total recently because it was calculated as being under-funded.

729. Not new money; it was just moved.

(*Professor Stout*) It was never new money; it was always top-sliced. That has not happened in Northern Ireland yet, so we are no longer comparable as far as funding STAR is concerned.

(*Sir Gordon Beveridge*) The second point is the medical library. Our present medical library, situated in the Royal, is only about a quarter of the size it should be and we have plans to re-organise our library facilities over the medical area but we do need an injection from the DHSS.

Lord Perry of Walton

730. A quarter the size in the accommodation or in the number of books?

(*Sir Gordon Beveridge*) It is in the accommodation.

Chairman

731. But your medical library is not in the University library itself?

(*Sir Gordon Beveridge*) It is situated in the Royal but part of the University library, but it does a much bigger function than just serving the University. It also serves the whole of the National Health Service system.

(*Professor Stout*) It is a joint health services/University medical library covering all the health professions and jointly funded by the University and the DHSS. The new medical library which we have realised we have needed since about 1973, when we first started discussing it, will be jointly funded. The University is prepared to put its funds in; the Department of Health so far has not done so and we are getting further and further behind.

Lord Butterfield

732. So much for a knowledge-based health service!

(*Professor Shanks*) To answer Lord Perry's point, there is inadequate space for storage of books and similarly there are an inadequate number of places for students and staff, etc.—it is about a quarter or a fifth of what is required. The medical library was opened 40 years ago and then the medical school was smaller, the dental school was smaller, we did not have nursing students. The staff of the hospitals and the medical school are much greater but the library has not changed in 40 years.

Chairman

733. How many dentists do you graduate in a year?

(*Sir Gordon Beveridge*) We take in 25 and most of these work through.

734. Is there any significant research income in the dental schools as far as you are aware?

(*Sir Gordon Beveridge*) Not really.

(*Professor Stout*) No, research has been poor in dentistry.

735. I know the story about your library. I have heard about it before.

14 February 1995]

SIR GORDON BEVERIDGE, PROF ROBERT STOUT,
 PROF ROY J MCCLELLAND, PROF ELIZABETH R TRIMBLE,
 PROF ROBIN G SHANKS, DR GEORGE BAIRD AND MR JAMES O'KANE

[Continued]

[Chairman contd.]

(*Sir Gordon Beveridge*) The third point was about the volume of our staff in comparison with other universities in England.

(*Professor Stout*) We find it very difficult to dissect out a comparison because of our joint appointment system. It would seem that if half of our salaries are paid from outside we should have twice as many staff. However we believe we are under-staffed. In particular, as we have already mentioned, we do not have significant numbers of staff fully funded by the health service. Professor McClelland, the Bursar and I are planning to visit some comparable medical schools across the water to see what is happening there, including Newcastle.

736. It is useful to visit Newcastle because that is one of the universities in England that went in for A plus B appointments.

(*Professor Stout*) We think this loss of volume of staff that has been referred to is part of our problem in uplifting our research.

Lord Perry of Walton: But the variability in the United Kingdom is enormous. In Edinburgh only 25

per cent of all the consultant posts are paid for by the NHS, whereas in Leicester it is 60 per cent and it really is tremendously different.

737. When I became Dean of Newcastle I was told in 1971 it was illegal to spend health service money on university appointments. The answer was to set up a joint committee between the health service and the university, so the region decided whether the individual had put a solid case and the university had to decide on the spot whether to give them a personal chair. It was an extraordinary arrangement but there is a lot of complexity. Just to encourage you about your library, when I became Dean in 1971 I was told that there would be a new medical school in five years and a new ward block in ten, and the new ward block opened last year and the library is excellent. Thank you very much indeed for giving us such absolutely invaluable information.

(*Sir Gordon Beveridge*) It has been a pleasure to have you here at Queen's University. Thank you very much for coming.

Examination of witnesses

DR J J M HARBISON, Under Secretary, Policy and Strategy Group, DR CLIFFORD HALL, Deputy Chief Medical Officer, MR PAUL SIMPSON, Management Executive, and MR ROLAND BECKETT, Strategy and Intelligence Group, Northern Ireland Department of Health and Social Services, were called in and examined.

Chairman

738. Dr Harbison, I would like to say thank you very much to you and your colleagues for coming to see us and for answering some of our questions.

(*Dr Harbison*) Thank you, my Lord Chairman. Thank you for your welcome and equally, can I say on our behalf how delighted we are that the Subcommittee has come to Northern Ireland. It is not a particularly frequent occasion that a committee comes to Northern Ireland and we much welcome the opportunity of meeting you on a home basis, as it were. If I could possibly introduce myself and my colleagues; I am the Under Secretary in the Department with responsibility for policy and strategy for the Health and Personal Social Services. On my left is Dr Clifford Hall, the Deputy Chief Medical Officer, and on my right, Mr Roland Beckett, who heads the Strategy and Intelligence Group, which is within the Department the professional core, which includes researchers, statisticians and economists, and Mr Paul Simpson is the Deputy Chief Executive of the Management Executive. I would like, with your agreement, my Lord Chairman, to take a few minutes to set the scene and to indicate where we are in terms of research within the HPSS. I know time is short so I will try not to take too much of your time. We are dealing with Northern Ireland which, as you probably know, has a population of about 1.6 million, a very small population. The major reforms of the health service all apply to us. We have had the full range of developments over the last five or six years. There are, however, a couple of unique features about our

health services in Northern Ireland which put a slightly different slant on to the reforms. First of all, we operate within an integrated provision of health and personal social services. We do not talk about the NHS, we talk about the HPSS, the Health and Personal Social Services. Our four Area Boards are the commissioners or purchasers of both health care and social care, so we have an integrated structure. That has some implications for the reforms in that we have had a development of trusts, as with the rest of the United Kingdom, but we have a unique hybrid animal called a community trust, and the community trust provides not just community health care but social care and social services for children and for other client groups. Again this is unique within the United Kingdom. The health and personal social services operate within a rolling five-year strategy. We have had a regional strategy for the development of health and social well-being through the HPSS and we are on to our third five-year strategy now, which runs from 1992 to 1997. We believe that our strategic framework predated *Health of the Nation* and other strategies in the rest of the United Kingdom. The research thrust within the HPSS takes its priorities and its thrust from the Regional Strategy. So we see our regional strategy for the development of health and social gain as the framework for all our action, including our research activities. In terms of research, we as a Department have a commitment to the importance of developing research in and on the HPSS. Our consultative document, which was published in 1993, set as our two broad aims: to ensure that improvements in

14 February 1995]

Dr J J M HARBISON, DR CLIFFORD HALL,
MR PAUL SIMPSON AND MR ROLAND BECKETT

[Continued]

[Chairman *contd.*]

health and social well-being are brought about by the influence of high-quality research on professional and management practice. The second broad aim was to foster and develop the Health and Social Services research capacity in Northern Ireland. You, I think, have received copies of our strategic paper. A number of objectives are identified: to assist in the process of making informed and cost-effective practice, management and policy decisions, to help formulate and evaluate objectives, to facilitate the monitoring and achievement of all targets for health and social gain. We have seven broad objectives. The paper was published in 1993. We at the Department level received 78 responses concerning the paper and the responses were really widely welcoming. I think there were two rather idiosyncratic individual responses who took a rather more negative view, but generally the overwhelming response to our strategy and our proposals was positive. A couple of areas of concern, however, were noted. One area of concern related to the role and remit of the proposed Director of Research and Development. Some respondents thought that the individual should be full-time and some respondents thought the Director should only take a very partial, part-time role. The bulk of respondents seemed to view a part-time Director as the way ahead. The second caveat expressed by a reasonable number of respondents related to the structures for developing research, both for advice and setting priorities within Northern Ireland. I think the view was that our initial proposals were rather bureaucratic; they were perceived as promoting the development of a Civil Service culture and that something rather simpler might well be a better way ahead. The Department has considered the responses and the actual strategy outlined eight separate areas of activity to develop the research and development base within the health and personal social services in Northern Ireland. With one major exception we have developed fairly well the strategy as outlined. The one area where we have not made the advance that we had hoped is the critical appointment of a Director of Research and Development. The Department has accepted that there is a need for a Director of Research and Development. However, within the current structures of the Department of Health and Social Services we are undergoing the pressures of down-sizing that a number of other Civil Service Departments are experiencing and we have had some difficulty in establishing how we can appropriately resource the Director and the support that the Director needs. The Department is currently undergoing a series of fundamental reviews of its organisation and structure on a similar basis to the Banks review in the Department of Health, and the Function and Manpower review. From this work we anticipate that we will identify where a Director of Research and Development will be appointed within the Health and Personal Social Services. As I say, there is no question that the Department accepts the need for a Director. I think we are considering how and where that individual can most appropriately be placed to take forward the work of integrating and developing the HPSS as a knowledge-based service. You may wish to come back on that. That is the only one of eight areas where we have not made the

development we hoped. On the other areas, just to mention them—developing the integration of Northern Ireland research activities with what is happening elsewhere in the United Kingdom, developing health and social services priorities for Northern Ireland, developing a survey strategy, developing and managing a rolling R&D programme, developing dissemination of information, efforts to enhance the research expertise and capacity—we have made, I think, a reasonably significant advance over the period since the strategy was launched.

739. When do you hope it is now going to be possible to appoint a Director of R&D and is it anticipated that that appointment will be made on a part-time basis?

(*Dr Harbison*) Obviously we have to go to our Minister for endorsement of the review proposals. On the assumption that the Minister agrees with our recommendations that the Department will be making to him, I would hope that within this current calendar year an appointment will be made.

740. And part-time?

(*Dr Harbison*) That remains to be discussed. There is continuing divergence of views. I think the current view would be probably part-time with the individual's other 50 per cent being involved in some related activity.

Baroness McFarlane of Llandaff

741. Paragraph 4.11 states that the Clinical Research Group will have particular responsibility to provide support for the development of biomedical and clinical research in the Province, including nursing, dentistry, pharmacy and allied professions. I wondered how this is working out in practice, what the relative allocation to nursing and to midwifery and professions allied to medicine is and how this is accomplished?

(*Mr Beckett*) Allied to the non-appointment of the Director of Research and Development, the formal structures that were, in fact, questioned by some of the responses have not been set up, but that, of course, has not stopped us continuing to support research and we have a number of research training studentships, of which seven are currently on offer or have been made, totalling £116,000, covering nursing, dentists, paramedics and pharmacy. That is in addition to our special Clinical Awards which are made each year, of which there are a number of grants and one year research fellowships. Those have been better developed and there is more money at the moment going towards those, but the whole issue of research training is one which we have identified as a priority and we have currently commissioned a view of how it is working and how we can perhaps better enhance research training within Northern Ireland.

742. I see the way in which the research studentships have been awarded feeds into this very important area of preparing people for research but I wondered about actual budgets for projects and the relative allocation for those?

(*Mr Beckett*) When you say "budgets for projects", many of the projects that the Department

14 February 1995]

DR J J M HARBISON, DR CLIFFORD HALL,
MR PAUL SIMPSON AND MR ROLAND BECKETT

[Continued]

[Baroness McFarlane of Llandaff *contd.*]

would fund are undertaken on a multidisciplinary basis, so that we would not have exact figures of how much has gone to clinicians, dentists and so on in that sense.

Chairman

743. Can you give us an actual breakdown of total expenditure on R&D in 1994-95 and can you tell us of the extent to which the NHS R&D Strategy in England and the Culyer Report have been taken up by the Department?

(*Dr Harbison*) Yes. In terms of the current planned expenditure for 1994-95, the total budget estimated at the start of the year is just under £8.5 million. The bulk of that comes from the research component of STAR, which you may wish to explore in greater detail—about £6.5 million estimated as the research component of STAR. The rest is spread across a range of areas—primary, secondary and community care, the Clinical Research Awards, public health research, plus four core units that the Department funds within the universities in Northern Ireland. We believe it is around 0.6-0.7 per cent of the resources allocated to the HPSS.

Lord Perry of Walton

744. I was slightly worried by paragraph 3.3 of your 1993 outline, where you said: "The NHS R&D programme will cover the full spectrum of R&D. However, the focus will be on evaluations of methods of disease prevention and treatment, and on research into the delivery and content of health care." The NHS R&D programme is 80 per cent STAR and I would have thought that it would be a disadvantage to the overall pursuit of academic biomedical research if the focus was removed from that in the way indicated in paragraph 3.3. Would you like to expand on that?

(*Dr Harbison*) I will talk a bit about Culyer and the Northern Ireland response to Culyer, which might take in some of your question. The same problems that Culyer faced existed in Northern Ireland. The reforms have, I think, put under pressure a lot of local research. There is concern as to the actual degree to which STAR in Northern Ireland supports research. There is also a concern that there is no similar system of support for R&D in primary care or in community care and there is a diverse system of funding which I think obstructs coherent priorities-setting. I think we would believe that the general recommendations that the Culyer Task Force have come up with seem equally applicable to Northern Ireland—better arrangements for setting and agreeing R&D priorities to ensure that strategic choices are made about the deployment of funds for R&D and for the service support of R&D, the creation of a single funding stream for R&D in the HPSS, developed as a levy on purchasers and new arrangements for the management of HPSS R&D in keeping with the new models in the HPSS. So, we believe that the general recommendations fit in with our objectives, which are to integrate R&D with HPSS management and to work closely with all purchasers to ensure that R&D is effectively

promoted in the HPSS and that the results are fully used. We hope to improve the targeting of funds for R&D, making them more explicit, more transparent, and to improve the management of R&D. How we do that within the Northern Ireland structures we do not know yet. We have established within the Department a small scoping group which Mr Beckett will be leading to look at the implementation of Culyer within Northern Ireland. We believe that when working through the implementation, we must involve purchasers, providers, the universities as well as the Department, but quite how we do that we see as a major task and we will be watching the developments in England as far as how Culyer is being implemented within the English scene with considerable interest.

Chairman

745. Culyer has proposed that in England, the 'R' component of SIFTR should be equivalent to 25 per cent of SIFTR. First of all, do you agree that the 'R' component of STAR is 25 per cent of STAR? Secondly, Culyer proposed that there should be within the disbursement of that 'R' figure three separate streams in a sense: that it should support health services research, it should support the infrastructure for the additional service costs of biomedical research in major units, and it should also support the provision of facilities to aid the performance of research. Do you accept those principles as far as Northern Ireland is concerned?

(*Dr Hall*) Yes, we have no problems with those principles. Could I go back to the previous question? Paragraph 3.3, I think, refers to the moneys made available for research other than SIFTR.

(*Mr Beckett*) Could I clarify that. What we have in 3.3 is a pre-Culyer situation and that is, in fact, our understanding of what the Department of Health's position was at that point.

746. It has changed since then?

(*Mr Beckett*) Paragraph 3.3 relates specifically to the Department of Health, not to Northern Ireland.

Lord Perry of Walton

747. But SIFT before you add the 'R' in was a special increment for teaching?

(*Dr Hall*) Yes.

748. And I presume that 75 per cent anyway of STAR is that?

(*Dr Hall*) Yes, that is right.

749. Therefore, it was directed pretty nearly solely at the teaching hospitals that supported the medical schools?

(*Dr Hall*) We directed it a little bit more widely than that. In Northern Ireland our system is slightly different in terms of allocation. All hospitals that accept medical students get some allocation from STAR. We have a weighting system but all hospitals that teach do receive some amount of money.

750. I am not arguing with that one. What bothers me is that I sat on this Committee when it made its first report that created the Peckham system. In other

14 February 1995]

DR J J M HARBISON, DR CLIFFORD HALL,
MR PAUL SIMPSON AND MR ROLAND BECKETT

[Continued]

[Lord Perry of Walton *contd.*]

words, we wanted to support health services research and the one thing we did not want to do was to prejudice the support of biomedical research in the teaching hospitals and what I was anxious about in the wording, whether it was pre-Culyer or not, was whether this was an indication that the Department was looking more favourably on spending money on health services research and less favourably on supporting the medical schools?

(*Dr Harbison*) My Lord Chairman, if I can come back, first of all, I think the particular paragraph related to national developments rather than within Northern Ireland. Secondly, we were talking about developments at a national level rather than a Northern Ireland level, as we understood them at that stage. But can I reassure you that we think, and we still continue to think, that health services research, both national and particularly in Northern Ireland, needs to develop, but not at the expense of traditional research. We would wish to maintain and strengthen it but really building on health services research. To that end we have established, and are funding, a health services research unit within Queen's University; the Health and Health Care Research Unit.

751. I appreciate the differences in the way in which your structure is set up in Northern Ireland. I do wonder whether that sort of difference is going to make it very difficult for the MRC and other funding bodies to treat you all fairly?

(*Dr Harbison*) I hope not. I do not think that any of the changes that are proposed are changes that we would envisage would get us out of line. The health departments have a Concordat with the MRC and I think that whatever decisions are taken at national level, they will be compatible with our developments.

752. That is reassuring in so far as it goes but, of course, the MRC support of researchers in Northern Ireland has been extremely small compared to the support in the rest of the United Kingdom. Therefore the Concordat does not guarantee very much at the moment. It may get better?

(*Mr Beckett*) That has been the case indeed and as part of a way to get into this and start to develop MRC involvement in Northern Ireland we are becoming involved in joint MRC special training fellowships in Northern Ireland and there are now some projects being jointly supported by the Department and by the MRC. It is a relatively new initiative that we have got involved in.

Baroness McFarlane of Llandaff

753. In paragraph 2.12 of the consultative document the Deputy Chief Nursing Officer has developed an Action Plan for Nursing Research. Under what kind of budget heading would that come? Would it be under health services research and is that Action Plan now in being?

(*Dr Harbison*) The Action Plan is in being. Our nursing colleagues' projects are bid against the departmental research budget with other health or social services research. The National Board also has a small research budget but has received additional funding for a number of research projects relating to Project 2000 evaluation.

754. So that would be educational research, would it?

(*Dr Harbison*) No, that is all funded by the DHSS.

Chairman

755. Would you care to comment on collaboration between the Department in Northern Ireland and other United Kingdom health departments or is there any collaboration in R&D with work in the Republic?

(*Dr Harbison*) Yes. First of all, Chairman, collaboration with other United Kingdom health departments: we liaise closely with the other health departments, particularly the Department of Health in London. I should say at this stage that our research arm within the Department is small. You actually see two-thirds of it sitting in the corner here for experience. We have three professionals. One of our problems has been to keep on top of the development of the R&D Strategy in England, which has been fairly dramatic, fairly impressive, in the number of groups and organisations, established. We try and keep in contact with the key groupings. We have very good informal links and our colleagues in the Department of Health are most helpful. I am on a number of committees; others are on a number of relevant committees. For a number of the developments, particularly relating to the information strategy and dissemination strategy, we have been closely involved with the Department of Health. We contribute to the Cochrane Centre, to the York Centre for Reviews and Dissemination and the Leeds Clearing House; we contribute in resource terms to those three centres, and we are on the management group of those centres. We very much "piggy-back" on key developments there. As I say, we have a membership on a number of the R&D advisory groups which we see as the critical ones. We are a member of a recently established United Kingdom-wide survey network to develop survey information in the health and social services area. We have mentioned the Concordats with the research councils which the various health departments are involved with, and we have observer status on the Department of Health Departmental Research Committee. So we have very good links, both formal and informal. The limitation on our behalf is in terms simply of numbers and linkages. Our colleagues in the professional areas equally assist in this development. In terms of the Republic, Dr Hall might wish to comment, as our main linkages there have been through our medical colleagues.

(*Dr Hall*) Yes, there are informal links between the CMOs of Northern Ireland and the Republic on a range of Health Service issues, but as far as the research is concerned, I think the linkages have been much less than they should have been, but they are developing. We have looked traditionally to the rest of the United Kingdom to form linkages on research and other matters but good progress has been made in strengthening our link with the Republic of Ireland in this area. For example, the Cancer Registries north and south work very closely together. There is very close liaison there. Our Drug Utilisation Research Unit has developed a close link with the Republic of

14 February 1995]

DR J J M HARBISON, DR CLIFFORD HALL,
MR PAUL SIMPSON AND MR ROLAND BECKETT

[Continued]

[Chairman *contd.*]

Ireland and is advising the Republic of Ireland on drug utilisation matters. But perhaps most importantly of all, we are currently looking at the setting-up of an Institute of Public Health which would be an all-Ireland body. We are still working out the detail as to how this might function and the links it should have, but it will have a very major research focus.

Lord Butterfield

756. I was very intrigued that your logo firmly had health promotion in the all-embracing surrounding arms and I have been concerned about it. It is a very difficult field. I was just wondering whether you had any general thoughts about it. You are talking about prevention of illness. We in the United Kingdom really do not have very clear ideas on how you change bad health habits. Some people—we like to think the wise ones—follow our advice and it is true, I suppose, that better-off people are always following advice and have better health statistics than those who drink and puff cigarettes and so on. I wondered whether you saw that this was going to be a major drive because the feel in your document is that somebody has this feeling in your Department and is putting it through?

(*Dr Harbison*) Yes. I mentioned in my introduction the Regional Strategy within which we operate. Our current Regional Strategy has identified four priority themes, of which one is health promotion: promoting better health. The other three, briefly, are developing care in the community, targeting health and social need, which relates to health inequalities—and again I might say I think we were the first health department within the United Kingdom to identify the issue of health inequalities as of considerable concern—and the fourth priority is streamlining acute care. We see the importance of health promotion but also the difficulties. We are currently finishing a review of health promotion arrangements within Northern Ireland. We do not think we have yet got the right arrangements for taking forward action and we have a review which is due to complete in the next couple of weeks. I think we see the thrust having to be made in a number of directions. One of the directions which the current Regional Strategy has highlighted is the importance of areas, departments and agencies, without the Health and Personal Social Services which impact on health gain and social gain. Arising out of our current strategy we have established in Northern Ireland an interdepartmental group on health which is chaired by the Permanent Secretary of the DHSS, which has senior policy officials from all the main departments in Northern Ireland. We are trying to link in the policies and actions of other departments—Environment, Agriculture, Education—increasingly to try to both alert them to their importance in health gain but also to bring, through the alliance concept with other departments, the other key agencies into the whole health gain area. We are currently working towards a roll-forward of our Regional Strategy and the steering group has agreed that this must be an area that we strengthen and further develop. So we see the wider

importance of other agencies and bodies. Within the HPSS itself, we see the staff of the HPSS as a critical component terms of their influence. They meet the patients—the clients—at the coalface. We are very much encouraging, through nursing, through general practitioners, the whole importance and role of practitioners in pushing forward the health promotion message. Equally there are other issues which relate to wider government policies such as fiscal policies, taxation on tobacco, advertising, which are outwith our responsibility but which strongly bear on these issues.

757. I give you an alpha. Could I ask you to go for alpha plus? Could you try to get some of your many very bright young people interested in this fascinating problem, which, if you could make a contribution to it from Northern Ireland, would be very welcome on the big island and, indeed, I would have thought throughout Europe? One of our problems is that we just seem to be paralysed when we are multidisciplinary and when we need information about how attitudes are built up through childhood. I think it is a marvellous kind of problem to get some of your very bright young students—it may not be from medicine—involved in trying to see a way through this dilemma. I am sure the answers are different for different people but it would be a great contribution if you could make something of it.

(*Dr Harbison*) We like to think that our size gives us some advantage.

758. A great advantage, and your culture being so—not completely uniform, but pretty uniform?

(*Dr Harbison*) Yes.

Chairman

759. Is any of this information likely to emerge from the population surveys which you have highlighted in your consultative paper or are those being organised for totally different reasons? What do you intend to achieve from them and is this approach distinctive to Northern Ireland?

(*Dr Harbison*) We believe that we need population level information on health and social well-being. We believe we do not have that information adequately at present.

760. And attitudes?

(*Dr Harbison*) And attitudes, yes. With that in mind, we commissioned a Review on the Survey Needs in Northern Ireland and a strategy to take forward our information requirements. That strategy was published for discussion. We have now put a formal proposal to our Minister, who has agreed and endorsed the survey strategy. We are now launched on a multi-year information strategy which is based round a general survey of health and social well-being, linked in with one-off surveys on a range of areas—child health, breast-feeding, smoking, drinking, dental health, many areas—plus a regular survey on attitudes.

14 February 1995]

DR J J M HARBISON, DR CLIFFORD HALL,
MR PAUL SIMPSON AND MR ROLAND BECKETT

[Continued]

Lord Perry of Walton

761. Who will carry it out?

(*Dr Harbison*) Some of the surveys are being carried out by the Government Central Survey Unit, from which we commission particular modules within some of their continuous surveys. The survey of health and social well-being we will design ourselves and it will be carried out for us by the Government Central Survey Unit. The survey is not unique to Northern Ireland. The other countries are all at different stages in setting in place population survey information. We believe we may have a more comprehensive approach to it. We are working very closely with our colleague departments. There is a United Kingdom survey group in existence, of which we are members. We believe that this is essential to develop the information on our population, at a regional level, and also we will be working with our Area Boards, so that the information is available at Area Board level as well as Northern Ireland level.

Chairman

762. I think it is important to ask whether you prefer that Northern Ireland should be part of the priority-setting processes of the NHS R&D Strategy with representation on the Central Research and Development Committee and lead responsibility for particular areas of research, or whether you would prefer a distinctly Northern Irish R&D Strategy with its own priorities?

(*Dr Harbison*) I do not think, my Lord Chairman, we can give you an either/or here. I would say again we are talking about a population of 1.5 million against England with 50 million. Obviously the R&D Strategy that Professor Peckham and his colleagues are implementing is of huge relevance, importance and value for us. Many of the issues that have been identified as priorities are our priorities as well. I have said, however, a couple of times, that we have our own Regional Strategy, our own regional framework. Within that we have highlighted a number of key health and social issues of relevance for Northern Ireland. Some of those are slightly different from the England and Wales priorities. We are concentrating our research effort there. The current departmentally sponsored research programme, for example, homes in on three areas. One is the very high level of acute admissions to hospital in Northern Ireland. We have higher rates of acute admissions than other areas of the United Kingdom. We do not understand why. Secondly, health inequalities, which I have mentioned: we are very concerned about the extent of variations in health and social well-being across our population geographically and in terms of different groups. In Northern Ireland there is the particular relevance that we have two communities, the Protestant community and the Catholic community, who differ on socio-economic parameters. They also differ on health parameters. So health variations in Northern Ireland take on a unique characteristic which is not in existence elsewhere in the United Kingdom. The third priority that we have homed in on is that we have a much higher dependence on institutional care for the elderly, whether it is continuing care in hospital, residential homes or nursing homes. We do not understand why, whether it is simply that we

have higher provision or whether there are other reasons for our higher dependence. So there are those three issues which are really specific Northern Ireland issues and which we would follow up through our research strategy, but again the key areas of coronary heart disease and the cancers which Professor Peckham has obviously identified, are equally of importance to us. So I think we want to use and benefit from the work in the English R&D but equally retain a capacity to route in on specific Northern Ireland areas.

Lord Perry of Walton

763. I had visits some time ago from the Welsh Office and I wonder whether you had an empathy with Wales as Celts. Do you have exchanges with them?

(*Dr Harbison*) Yes. As I say, we link with the three other home health departments, but I would have to say that of the three probably Wales the least. We have strong links with Scotland and we have very strong links with England, as I have indicated. We have contacts Wales with but not as strong as with the other countries.

Chairman

764. Some concern has been expressed to us in England over contracts that have been drawn up by the Department of Health, on the one hand, with commissioned research units designed to undertake a specific pattern of activity, on the other, funded from the R&D budget. In those contracts it has been specified that no publication arising out of the research will be submitted to a journal or to any other mechanism of publication without the prior approval of the Secretary of State. Is this something which is familiar to you and is it a requirement your Department is likely to accept? It has caused great concern amongst the research community.

(*Mr Beckett*) That is not something that we normally do in Northern Ireland. We do require the researchers to submit their research reports to the Department prior to publication.

(*Dr Harbison*) For comment.

(*Mr Beckett*) For comment, but we encourage them to publish and we do not veto. There have been no occasions that I am aware of where we have vetoed.

765. No, the contracts we have seen have said that consent will not unreasonably be withheld. Nevertheless, it seems to establish something of an embargo upon the publication of the results of medical research which in the past have been regarded by researchers as being something that is always done.

(*Mr Beckett*) I think what we are concerned with when we are funding research is that we are aware of what the researchers are going to say.

766. And of the implications, of course.

(*Mr Beckett*) So the Minister can be in a position to react if there is something significant in the findings.

767. But if all research funded from the R&D budget of the entire National Health Service had to be submitted to the Department of Health, they

14 February 1995]

Dr J J M HARBISON, Dr CLIFFORD HALL,
Mr PAUL SIMPSON AND Mr ROLAND BECKETT

[Continued]

[Chairman *contd.*]

would be swamped with paper. I cannot see that it is likely to be feasible, but still, thank you for your helpful comments on that. The NHS in England has set a target for R&D of 1.5 per cent of its total budget. Do you have a similar target for Northern Ireland?

(*Dr Harbison*) No, we have not, my Lord Chairman. Again in my introductory comments I said our current assessment of our research funding is around 0.6-0.7 per cent. Because of the difficulties of STAR or SIFTR we genuinely do not know how much funding is going into research or on service support of research. We hope that post-Culyer developments, we will be in a position to be able to say how much we are currently funding. We as a department have a commitment to increase the amount of resources going on R&D but, because we do not know when we are starting, we have not set ourselves a target.

Baroness McFarlane of Llandaff

768. The National Board for Nursing, Health Visiting and Midwifery has this minimal research budget of £10,000, but what has been achieved by it?

(*Dr Harbison*) First of all, there is the research budget of £10,000. In fact, the Board has considerably enhanced funding from both the Department's research budget and the ME separately for some of the work, particularly on the evaluation of Project 2000, methods of assessing competency, development of effective measuring instruments, and I gather that these projects are currently under way.

769. So that is an evaluation of methods of education?

(*Dr Harbison*) Yes, and also, as I say, assessing competency, the effectiveness of measuring instruments, etc. In terms of the effectiveness of the work, I think it is too early to give you any comment because the work is not complete.

Chairman

770. Would you care, then, to tell us about any of the R&D activities of the four Health Boards and what you see as having been achieved by those activities?

(*Mr Simpson*) I have a lot of detailed information with me about the sort of research that, as you said, the four Boards have been undertaking and I do not intend to go through that.

771. I think if you submit that in writing afterwards that will be extremely helpful.

(*Mr Simpson*) I think it is fair to say there is a quite impressive record of research across a whole range of issues, both unidisciplinary and multidisciplinary, both local issues, neighbourhood issues, and also thematic issues across Boards, which are recorded here and we will leave that with you.

Lord Butterfield

772. To what extent is this research that has welled up in the minds of your staff, junior, middle grades or above, without actually being fed a research grant at the beginning? One of the things that I know we four feel quite strongly is that if the climate of your health service is encouraging people to start work just out of their brains and out of whatever it is in the way of test tubes or balances or whatever, then you have every prospect of a very knowledge-based service to be developing and I wonder if you can say if those regional reports indicate any work that just grew up without ladling money in?

(*Mr Simpson*) I think that the evidence which we shall present to you does demonstrate that there is a tremendous variety of work which is coming forward and it is, in fact, very largely driven by local issues, local concerns. We do try, obviously, to set some regional targets, some regional objectives, through devices such as those Dr Harbison mentioned on the Regional Strategy, in which we set our overall objectives. Some of that obviously drives some of the research but a large amount is very much locally driven and, as you say, comes largely through the public health departments of the four Boards, and basically it is people, consultants in public health, registrars in public health, to a greater or lesser degree working with other professions in the Board, working together on local different projects.

773. That is absolutely fine so far as epidemiological public health research is concerned and even health service research, but one of the great strengths in England has been that the regions have all had a locally operated clinical research scheme, with a research committee and budget to which any young doctor or consultant in the region can apply for a research grant to carry out a particular piece of work, and often grants have been obtained, by people taking their first steps in clinical research, often leading subsequently to major grants from other bodies such as the MRC. Have you anything comparable?

(*Dr Harbison*) We have an award system called CRAAC, which I will ask Dr Hall to expand on.

(*Dr Hall*) CRAAC stands for the Clinical Research Awards Advisory Committee scheme and during 1994-95 we made available approximately £½ million through this scheme. The scheme is advertised towards the end of the year and we grant both fellowships and research grants which are available to medical graduates and other health professionals. As far as fellowships are concerned, they are confined to graduates of medicine, dentistry and the basic medical sciences, whereas grants are available more widely to anyone working within the health field. Applicants for fellowships are interviewed by a committee which is chaired by the Dean of the Faculty of Medicine at the Queen's University of Belfast and consists of academics and clinicians covering the main clinical areas and the basic sciences. All applicants for fellowships must have sponsors who will have assessed the quality of the applications before they are submitted to the committee for consideration. Last year we granted ten fellowships and 46 grants.

14 February 1995]

DR J J M HARBISON, DR CLIFFORD HALL,
MR PAUL SIMPSON AND MR ROLAND BECKETT

[Continued]

Chairman

774. Does that embrace the DHSS Clinical Research Awards?

(Dr Hall) Yes, it is the same scheme.

775. What about the DHSS research students in dentistry, nursing, pharmacy and the therapies? Is that a separate head?

(Mr Beckett) That is separate and I referred to these earlier.

776. And what sort of funding again, would you remind me?

(Mr Beckett) It is £116,000.

777. Thank you, that is very helpful.

(Dr Harbison) My Lord Chairman, the Committee may be interested to know that we actually carried out an evaluation of the Clinical Awards Scheme last year.

778. Yes, I saw that, 1993.

(Dr Harbison) That was really quite encouraging and if it would be of interest to the Committee we will pass copies of that to you.

Lord Perry of Walton

779. Could I come back to the target of 1.5 per cent of total expenditure on the NHS. The current figure in the United Kingdom is estimated at 1.2. You say in Northern Ireland it is estimated at 0.6?

(Dr Harbison) Yes.

780. That is a very considerably lower proportion of the total expenditure.

(Mr Beckett) I think one of the issues here is that we may not be comparing like with like. The figures we are quoting to you are figures directly supported by the Department. We are not including in those any research supported by our Health Boards or directly by hospitals or research being done within those. That is part of the reason why we have not set a target to get to because we do not have a precise figure on that. That is something we would expect to be looking at much more closely in the follow-up to Culyer.

781. We are told by the health department in England that they do not have the figures either for quite a lot of the bits of research but they still estimate it at 1.2 and it does seem a very significant difference?

(Mr Beckett) We have not included any estimate at all. I would need to check the Department of Health's figures but if you are implying that they have included an estimate for research going on within and funded by the health service, we definitely have not in Northern Ireland.

(Dr Harbison) I think the other point here is that the SIFTR component or the research component of STAR is so dominant within all these figures that really the validity of those as a measure of research support is a critical issue and, as I indicated earlier, we feel we just do not have the basic information or evidence as to the research component of STAR. We take it as 25 per cent.

Chairman

782. We have left deliberately to the last the whole issue of clinical academic medicine because there is great concern in England, and I gather from what we heard this morning from your colleagues this concern is shared in Northern Ireland, about the present and future prospects in clinical academic medicine. The things I would like to ask you about in particular are the extent to which you feel that the Northern Ireland health service is likely to fund clinical academic posts, as the regions have been doing to a considerable extent in England, if only because there is good evidence that if you use health service funds to create, for example, a chair in a specialty which has been under-developed, it has a major influence upon improving patient care. Secondly, the question we must ask you is what you see as being the effects of the Calman Report on postgraduate training on recruitment into academic medicine?

(Dr Hall) I was surprised, my Lord Chairman, that you said there was concern within Northern Ireland about the training of clinical academics. Certainly that has not been drawn to our attention. Our system here is based on the joint appointment system and perhaps I can take a second or two to explain that to you?

783. Yes?

(Dr Hall) It is quite fundamental. In Northern Ireland clinical academics are appointed jointly by the university and the health authority and their salaries are shared on a fifty-fifty basis. This has resulted, we think, in the past, in there being fewer problems between the health service and the university than perhaps exist in some parts of the United Kingdom. As I said, their salary costs are shared fifty-fifty but the health authority pays any merit awards that are made to joint appointees. As far as funding is concerned, under the STAR system the Department now reimburses the health service component of that salary, that is 50 per cent, so in fact the university is only responsible for 50 per cent of salary and we think this is fair. There have been occasions when the health service has funded the total cost of joint appointment posts for a period of time, normally until the university is in a position to pick up its share. But that is our position. We feel that through STAR we are supporting academic medicine to a very substantial extent. The actual sum will amount to £3.16 million in 1994/95.

784. I think the concern that was expressed is for the fact that under the UGC and more recently the Higher Education Funding Council the actual level of funding available to universities and to clinical medicine has been savagely cut and that many posts have been frozen and some, indeed, have been lost permanently, and that for this reason, despite the fact that many of these posts are jointly funded, in clinical academic medicine there is now a disincentive to recruitment and there is also a considerable disincentive to young doctors, for instance, working in the NHS as registrars and senior registrars at present, to take lecturer posts if only because the prospect of obtaining a career post in academic medicine is very much less than it once was.

(Dr Hall) Of course, there has been downward pressure within the university on teaching posts. We are aware of that, but our approach has always been

14 February 1995]

DR J J M HARBISON, DR CLIFFORD HALL,
MR PAUL SIMPSON AND MR ROLAND BECKETT

[Continued]

[Chairman *contd.*]

to support clinical academic medicine, as I say, through the joint appointment system, which we think works very well, and I would say to the university if they have concerns we would be very happy to discuss them.

785. What about the Calman Report and the integration of the registrar and senior registrar grades and the reduction in the period of training?

(Dr Hall) Yes, we are taking that forward. We do control medical manpower in Northern Ireland very tightly indeed. In fact, we achieved a balance between consultant requirements and the numbers of training grades some few years ago and now with Calman we are facing the position where we are going to have to expand the training grades in the short term to fuel the consultant expansion which is due to take place. We discuss with each specialty annually the career grade requirements in that specialty, so we review our manpower plans annually for each specialty. In doing so, we take into account not only service requirements but also the requirements of academic medicine because ours is a single planning system which takes account of both.

786. The importance about Calman is the issue as to whether it is now going to be attractive to the young man or woman in a training post in medicine to step aside for two or three years to undertake clinical research training before going back into the clinical training stream?

(Dr Hall) Yes, that is an issue which has been discussed many times. I do not think anybody has the answer to that. I think much will depend on whether people who complete the shorter training period for, say, a consultant post, can get a consultant post immediately or not. I suspect there will be a number of people for whom there will be a delay and they may at that stage take the opportunity of engaging in clinical research.

787. What about the potential effect of the Kendell Report on the future of Distinction Awards, though we understand that that has not yet been accepted by government?

(Dr Hall) No, it has not been accepted by government as yet.

788. So you would not wish to comment on that?

(Dr Hall) No, I think not.

789. Or upon locally negotiated pay?

(Dr Hall) I prefer not to comment on that. I have my own views, needless to say, but I think there is almost an impasse between the profession and the government at this point in time.

Lord Butterfield: A word of congratulation. We were told that the lowest to get into the medical

school in Northern Ireland was two As and a B and that you went up to six A-levels at the top and five is not uncommon and there are many with four, and that indicates that the profession is attracting some pretty good people. I think we are terribly anxious that we do not leave any stone unturned to protect the profession in continuing to attract those young people and giving those young people's minds plenty of reign to make their full contribution to the knowledge-based health service in the future.

790. You are concerned in Northern Ireland with research, not just in the hospitals, not just health service research, not just biomedical research but research in the community. It has been put to us by the general practitioners whom we have seen that there is a case to be made out (a) for the establishment of a limited number of research general practices with supplementary funding systems coming from the Royal College or from other sources, and (b) for giving funding to general practitioners, say, to have one or two funded research sessions in order to be able to undertake research in the community. Is this something which you in Northern Ireland would commend?

(Dr Harbison) I think we are concerned to enhance research within general practice. The Clinical Research Awards are open to general practitioners but we have been having considerable difficulty in attracting acceptable applications. In fact, it is one of the areas that we would wish to encourage.

(Dr Hall) This is absolutely so. One of the ten research fellowships is earmarked for general practitioners but the number of applicants is really very small and the quality of the applicants is not as high as we would like. Also, as Dr Harbison said, the CRAAC scheme is open to applications from GPs but the number of applications is very small and again the quality less than we would like to see.

Lord Perry of Walton: The Health Department in Scotland provides the academic departments of general practice in the four medical schools with an annual grant of, I think, £200,000 to pay general practitioners who take part in clinical trials. That is one central way that one country is using to support general practitioner research. I only discovered that the other day.

Chairman: Dr Harbison, Dr Hall, Mr Simpson and Mr Beckett, thank you very much indeed for coming and we look forward to having the supplementary information which you have so kindly offered us.

MINUTES OF EVIDENCE
TAKEN BEFORE

**THE SELECT COMMITTEE ON SCIENCE
AND TECHNOLOGY**

(SUB-COMMITTEE I: MEDICAL RESEARCH AND
THE NHS REFORMS)

Wednesday 15 February 1995

Dr Peter Doyle

Professor John Swales

Printed pursuant to the Order of The House of Lords of 22 November 1994

LONDON : HMSO

£5.80 net

WEDNESDAY 15 FEBRUARY 1995

Present:

Butterfield, L.

Nathan, L.

McFarlane of Llandaff, B.

Perry of Walton, L.

Walton of Detchant, L.

(Chairman)

Memorandum submitted by the Association of the British Pharmaceutical Industry

The Association of the British Pharmaceutical Industry is grateful to the Sub-Committee for giving us the opportunity to give evidence to its enquiry on the above subject. Our comments are as follows:

We have always welcomed the setting-up of the NHS R and D Directorate under the leadership of Professor Michael Peckham, and have established regular liaison with the R and DD team. The development of the Directorate has continued to command our respect and support, and we have had several formal and informal opportunities to present evidence or comment on various issues being addressed by the R and D team. Thus we have ensured that they are aware of the importance we give to research and development within the NHS in regard to the better use of medicines—particularly new and improved medicines which are themselves the product of successful research.

Our contacts with the Regional Research Committees and the Regional Directors of R and D have been less frequent than our contacts with the central team, including Professor Peckham himself, Dr John Toy, Professor Gibert Smith and Dr Peter Greenaway. However, we have had numerous opportunities to address the regional team, all of which we have taken.

We have been observing the activities of the Cochrane Centre ever since its inception, and whereas we have strong support for the concept of meta-analysis we have some concerns over the validity of the process when it comes to comparing the published evidence for the use of a named pharmaceutical treatment now with the published evidence for the use of a product introduced, say, 20 years ago—when techniques for evaluation were less sophisticated than they are now.

Concerning the York Centre to which you refer, we are strongly in favour of studies into the cost-effectiveness of treatment, believing as we do that medicines by and large provide a significant and cost-effective part of the overall treatment able to be provided by the NHS. Collaboration on health economic studies would always be welcomed, and our own Office of Health Economics, under the directorship of Mr Adrian Towse, is available for consultation.

With regard to the Culyer report, we wrote to the Secretary of State for Health in October 1994, welcoming it and commenting on five of its recommendations. A copy of this letter is attached, and should be considered as our response to Sub-Committee 1 on this particular issue.

You finally ask us whether we have identified additional challenges or opportunities for UK medical research, which neither the NHS Strategy nor the Culyer report addresses. This gives us the opportunity to state in the strongest possible terms how important we believe it is—for the country as a whole and for the NHS—to have a resilient research-based pharmaceutical industry based in this country. Both the UK parent companies—likely to be reduced soon to just three—and the UK subsidiaries of multi-national companies based elsewhere are investing heavily in R and D for new and better treatments for a wide range of diseases, including Alzheimers disease, metabolic disorders and so on.

Recent events demonstrate that the pharmaceutical industry is currently unstable, and anything which undermines confidence in the UK as a country in which to conduct pharmaceutical research must be avoided. Members of the House of Lords Select Committee are in a unique position to advise the Government that the benefits to the country of a strong research-based pharmaceutical industry should more than compensate for an easing up of the constant pressure being applied to pharmaceutical companies to reduce the cost of medicines for the NHS. If R and D suffers because it becomes unaffordable, then planned and unplanned advances in treatment will not occur.

Should the Sub-Committee so wish, we would be very willing to provide additional oral evidence to augment the above written comments.

Dr Frank Wells

Director, Department of Medicine, Science and Technology

27 January 1995

15 February 1995]

[Continued

Letter to the Secretary of State for Health

We have received with interest the above report which has been the subject of extensive consultation with our member companies, and has been considered in depth by our Medical Committee—advised by my colleague Dr Frank Wells. We welcome this report and would specifically comment on five of its recommendations.

1. We support the recommendation creating a national forum to exchange information about the research strategies of the national bodies which sponsor or support R&D in the NHS (3.6).
We would expect to be involved ourselves in this forum, and it is appropriate for me to put on record our appreciation of the working relationships which are developing between ourselves and the NHS R&D directorate. We are, of course, pleased to note that the Culyer report itself includes many of our own comments submitted earlier this year.
2. Whilst understanding that the Central Research & Development Committee (CRDC) will be recast, we support the recommendation that the membership of the CRDC should be reviewed as set out in the report, and would specifically highlight the relevance of industry representation on the Committee (3.13).
3. We support the recommendation that the regional offices' Directors of R&D should be the focal point for R&D within each region. We particularly wish to emphasise the need for stability and security for each RDRD and believe this should clearly be given now despite the planned metamorphosis of Regional Health Authorities in 1996 (3.24).
4. We believe it is good business sense to derive a single explicit funding stream of official funds, and therefore support the recommendation set out in paragraph 3.28. We must emphasise that such single explicit funding cannot cover external funding from such sources as industry, but we believe the streamlining of internal funding to be essential.
5. We wholly support the recommendation that purchasers of health care allow providers the freedom to support pre-protocol work, curiosity-driven research and similar activities (3.39).

I hope you will find our general support for the Report, and our specific comments on these five issues, to be of help in determining the future of R&D within the NHS.

Dr Trevor M Jones, BPharm PhD FPS FKC CChem FRSC MCPP

Director-General, ABPI

27 October 1994

Examination of witness

DR PETER DOYLE, Research Director of Zeneca Limited, was called in and examined.

Chairman

791. Good morning, Dr Doyle. We have, of course, had a document in evidence from the ABPI which we have read with interest and I have just received the annual review from the ABPI as well which is relevant to our inquiries. If you would begin by introducing yourself and your company and could you give us some indication of your involvement with the NHS in the area of research and development?

(Dr Doyle) I am an executive director of Zeneca with the particular responsibility for R&D having exercised that before with ICI. I have spent about half of my 30 odd years in industry in the pharmaceutical industry. I have been a member of the Medical Research Council for four years, finished last year, and was on the Advisory Council for Science and Technology for three years before that was wound up. More recently, I am a member of Michael Peckham's Standing Group on Health Technology Assessment. I am now a member of the CRDC—since December, therefore, I have not actually attended a meeting so I have no views on its *modus operandi*. I am currently also a member of the Royal Commission on Environmental Pollution which is looking at soil pollution, as you probably know. Zeneca is involved in drug development fundamentally and that is the main interface with the

health service. Also it has a smaller but still important interaction through the development of new gene probe based diagnostics, for example, for cystic fibrosis but with an interest in genetic disorders across the spectrum. That is, I think, the principal interaction as a company we have with the health service.

792. Thank you. What is your own personal scientific background?

A. I was trained as an organic chemist and naturally have become over time more of a generalist, with a particular interest, but at a very superficial level in true scientific terms, in the whole development of genomics and in biotechnology, particularly in a health care context.

793. Are you working at all on the use of viral and other vectors for gene therapy?

A. We are not doing in-house research in viral vectors. We have a group which is concerned with what you might call the genetic approach to human health. I think I would say that our principal target would be to look at how you can turn the regulation of genes into what is known in the trade as "small molecule" drugs rather than large proteins. Clearly gene therapy is going to be a major development in health care worldwide so we are very, very interested in the whole concept of gene therapy and in that area

15 February 1995]

DR PETER DOYLE

[Continued]

[Chairman *contd.*]

the question of vectors, particularly the attractiveness of non viral vectors, how you get tissue specificity of expression is going to be fundamental in my view to the effectiveness of this approach to therapy.

794. You chaired the recent ACOST study on medical research and health; would you like to tell us about it? Can you give us some indication of your conclusions and what do you think ought to be done?

A. The prime objective of that study was to identify how recent advances in science and technology can be used to provide improved health care in the most cost-effective way. The background to the study was really the recognition that advances in biological and physical sciences opened up an unprecedented opportunity to improve existing technologies and to add new technologies which can improve health care. The study chose to be selective and focus on certain medical and health advances that were clearly possible, looking particularly at how effectively these were being put into practice and where possible—and this is more difficult because it needs time—the extent to which they have contributed to the delivery of improved health care in a cost-effective way. In a sense I think the themes of that were very much in tune with some of the developing trends in the health service I certainly see as an individual through the company, in other words a strong emphasis not just in improving health care but in doing it in a particularly cost-effective way. I think also we wanted to suggest how exploitation of the very considerable national investment we make in medical and health R&D could be improved through looking at the technology transfer links between the health service, industry and the science base in the United Kingdom. Now there were, of course, a number of recommendations, that is the inevitable outcome of any considerable study. The principal of these in my mind was the really strong endorsement of the steps that we saw already being taken by the Department of Health to promote health technology assessment by ensuring that all new devices or novel applications of existing devices were developed in a controlled way that therefore permits a much more rigorous examination of the sort of contribution they can make to health care, in a sense seeking something closer to the assessment, the close scrutiny that goes on for new pharmaceuticals or for extension of uses of existing pharmaceuticals. The key to this approach would be, of course, the installation of a much more evaluative culture into the health service and the need for identifying mechanisms for effective dissemination of good practice and the means to stop bad or ineffectual practices which I think are acknowledged still to be prevalent in the health service. I must say I believe the establishment of the Standing Group on Health Technology Assessment under Professor Sir Miles Irving is a massive step forward in achieving that approach. There was also a strong recommendation that the Health Department establish a Committee on the safety and efficacy of surgical procedures so that there would be a body with whom new surgical procedures or extensions of existing ones could be registered in a formal sense. That was made, in a sense, to emphasise the

seriousness of the problem over somewhat unregulated surgery. It had the firm backing of a number of eminent surgeons who were on the specific task force and they looked as an example at minimal access surgery but I believe the principles they adduced were applicable across the whole range of surgical procedures.

795. Thank you very much.

A. I was going to say that subsequent, in terms of concentrating the action, I think there was an acceptance of a need to keep surgical procedures under review but not as far as going to establish a formal committee. The Standing Group chaired by an eminent surgeon has actually taken this up through its acute sector panel and now has come up with some recommendations for training, review and audit that are under surveillance now by the gathering of Royal Colleges. There has been substantial progress.

Lord Butterfield

796. A man called Guise wrote a very nice essay about research for Lady Thatcher—she was Mrs Thatcher then—for the Policy Unit. In it he made a very important point which was the difference between value for money as you judge it as a return on capital and value for money when you think of penicillin. I just wondered whether value for money is thought of as a return on capital mostly in the pharmaceutical industry at this stage or are there dreams where you can see that in fact the contribution in the longer term is just an enormous if unmeasurable thing?

A. I think if you are working in the pharmaceutical sector and you are involved in a public company you inevitably have a fiduciary duty to shareholders.

797. Yes.

A. You have broader interests, of course, because you are involved in a very broad community of public, local communities, etc.. I think almost everyone I know who is in the pharmaceutical industry is interested in two things. One is of course the performance of the company where they have a duty, particularly if you are an executive director, to make sure it is properly exercised. I think what most people see as extremely important, they see it as a service industry, working in an agreeable conspiracy with health services and with all those concerned in medical research and health care to provide treatments which are value for money. It is not something where we should simply focus on one parameter.

Chairman

798. The last enquiry conducted by this Sub-Committee was into international investment in United Kingdom science. I do not know whether you have seen that report but it was produced and published in December.

A. If I have, I have not read it, my Lord.

799. One thing that came out rather strongly in the evidence was the suggestion that overseas companies in the United States and in Japan in particular were

15 February 1995]

DR PETER DOYLE

[Continued]

[Chairman *contd.*]

more prepared to invest in British science with a view to long term rewards, rewards which would be achieved perhaps in ten or even 20 years time. It was alleged, rightly or wrongly, that British companies were more concerned with short termism, that they wanted to see a rapid return. Is this something that you would agree with?

A. I would make two observations I think. One is it is really not possible in pharmaceutical research to see a rapid return. It is not inherently a short term business, with drug development times and the investment needed. I would say our interests are fundamentally in exploratory research. I think the attraction of medical research and health research is it is mission orientated so it has to straddle the whole spectrum from basic research right through to applied research. I would have thought that all pharmaceutical companies would firmly support the idea of the need for basic research, of which there is a very considerable proportion in the United Kingdom. I would not argue whether the quantum is sufficient but if you look at the Medical Research Councils, what goes into universities and the likely to grow even larger contributions from Wellcome Trust, the basic science underpinning in medical research is relatively sizeable. Not surprisingly I think large pharmaceutical companies will concentrate on strategic and applied research taking the view, which may be reasonable or not, that through the corporation tax, through the tax of individuals they have in a sense made a contribution in other ways to the national good which is reinvested.

800. Looking at us as an interested observer, what would be your view about the United Kingdom health technology industry, for instance the medical equipment industry as distinct from the pharmaceutical industry?

A. I suspect—and this really came to me through the ACOST study—that probably we have an industry which is less appreciated than it deserves to be. I think we have in major elements ceded to overseas the development of scanners and large instruments. All the evidence I have seen through people like Smiths Industry, etc, is that we have a rather healthy devices and instrumentation group of the smaller type which has a high export potential as well. We have got a probably somewhat under-rated industry there which is dwarfed by the fact that we are fortunate to have in the United Kingdom some of the major international pharmaceutical companies. Certainly that came out much more clearly than I had appreciated through the ACOST study.

Baroness McFarlane of Llandaff

801. We would be interested if you would describe how a pharmaceutical company goes about setting up a clinical research project in a National Health Service setting and how such a project is funded?

A. First of all, it is important to say that the National Health Service I think represents a most important and almost unique test bed in terms of applied research in new health care treatments, particularly pharmaceutical. So it is critical for the pharmaceutical industry. It is, of course, a necessary

element of any drug development but it is not a sufficient one because all drug development is done on an international scale. So development programmes have to be conducted abroad as well as in the United Kingdom, that is pretty fundamental if you are going to have international acceptance. We use clinical researchers and get involved in development either through individual researchers, we may do it through involvement in a specialised unit such as at the Edinburgh Unit for Clinical Metabolism or we may contract with organisations who provide under contract particular clinical trials. So we use all modes of interaction with the health service. These we pay for according to a contract which will vary whether you are dealing with individual units or a contract organisation. Our preference I think would be to pay on a per patient basis. The principles are does the clinician have expertise and preferably experience in the clinical condition you are seeking to investigate; will he give on behalf of himself and his colleagues a commitment to good clinical practice and has he access to the right number of patients of the right quality to provide a quality result that is auditable to the highest standards? We would prefer to establish a contract with a strong orientation towards a per patient payment. That is slightly unpopular but we end up recognising that there is a rough costing guide that we can establish between different centres and comparing the United Kingdom to other countries.

802. Does that budget include any of the institutional costs, the costs of beds for research?

A. We will pay what we would regard as fully overheaded costs. I have to admit to not knowing the precise details but I assume that we are not being able to do it on a marginal costing basis, the culture particularly now is such that—and it is a reasonable expectation—you pay for the direct costs and the overheaded costs as well. Also sometimes we have to provide assistance to individuals and these will be of benefit to the health service because they will only be involved part-time in drug development. In certain cases, we have a recent example from one of our drugs, we provide specialised equipment which of course after the study remains as part of the health service's infrastructure.

803. You have mentioned the overseas testing, and we wondered how the costs compared *vis à vis* this country and overseas countries?

A. It will come as no surprise to your Lordships that the most expensive trials are conducted in North America, in the USA and in Canada. The cost there can vary from two to at the extreme five times that of the United Kingdom and Europe, two times is more common frankly and sometimes one and a half. It is always more expensive. Within West Europe, you will find that Sweden will be at the top of the league in a sort of per patient basis if you analyse it that way. The United Kingdom is reasonably in the middle, Spain would be at the bottom and if you use Eastern Europe—and there are some remarkably good centres, for example in the Czech Republic—the cost is about half the United Kingdom. So if you take it from the least costly where quality is not compromised compared to the most, there can be an order of magnitude difference. In general we would

15 February 1995]

DR PETER DOYLE

[Continued]

[Baroness McFarlane of Llandaff *contd.*]

be saying it costs you twice as much to do it in the USA as in the United Kingdom.

Chairman

804. Because of constraints upon extra contractual and tertiary referrals it has been suggested to us that since the reorganisation of the health service in the United Kingdom it has become rather more difficult to conduct major clinical trials than in the past. Is this your experience?

A. Yes, it is certainly a bit more difficult and more costly. We noticed a rise in the costs greater than inflation.

805. Before Lord Butterfield comes in, could you clarify one point, when you talk about per patient—

A. The trials we are talking about require in an international sense about three to four thousand patients for a regulatory study.

Lord Butterfield

806. I was wondering whether there is any move towards loaning your staff to academic units in NHS hospitals? I ask this because long ago David Long was the clinical research director for Wellcome and he loaned me a man called Tom Hanley who beavered away in a laboratory in my department at Guy's. His major contribution to me personally was to evolve Allopurinol himself, almost single handedly. I have gout so I am very grateful. I wonder whether this very interesting way of symbiosing your great industry and all that you have got going for you and all we like to think we have got going for us in the academic world, whether that is a technique which is being used still? This was 30 years ago.

A. It is an interesting idea in principle but my feeling would be that it would be out of tune with the times. Frankly I think our medical advisers, who are of course all qualified physicians, do not have simply the clinical expertise that you would expect to get in a teaching hospital. It is now a very sophisticated business with enormous restraints in terms of protocol and development.

807. I am not making myself clear, sorry. David Long recruited Tom Hanley from King's College Hospital to join Wellcome [.....]. He recruited him and said "What do you want to do?" and he said: "I would like to go to Guy's". So we got a senior registrar if you like on his way up. The reason he got Allopurinol was that he had read the Wellcome's list of possible enzyme inhibitors in cancer therapy which came out of a New York laboratory. I do not want you to think we are looking for the sort of people who have committed themselves to the industry, to be located in academic units, I am just thinking it might not be a bad way of getting collaboration with people like Keith Peters if you give him a couple of senior registrars.

A. It is an idea to take away.

Lord Perry of Walton

808. When you said you paid the whole cost including overheads, would that include the cost of tertiary referrals because tertiary referrals are transfers of money from one hospital trust to another hospital trust. If you are paying that cost from outside the money is still going to the first trust.

A. I think the answer is I do not honestly know. I would be surprised if that happens too often. Generally what we contract with, and I am thinking of a multi-centre trial, is with an individual clinician who will have access to patients. In a sense it is of secondary interest to us where the patients are located, what is of prime interest is that there is an agreed and understood protocol and there is a commitment to good clinical practice wherever the patients happen to be seen. We will end up with a contract which covers the cost in the total sense wherever the patients are located under that specific clinician.

Chairman

809. If a particular trust required additional funding to enable it to attract the patients that the clinician required to be involved in such a trial, you would be prepared to consider the additional funding?

A. We would look at the total cost then and compare it with other centres.

810. Yes.

A. And then compare that with value for doing it here as against doing it in France, Germany, etc..

811. If we leave aside the whole question of overheads, do you think the pharmaceutical industry's approach might be usefully adopted by other purchasers of research in the NHS such as the MRC and charities?

A. In the sense of paying overheads?

812. No, I said if we leave overheads aside, can we consider that they would perhaps purchase research in the NHS on a similar kind of basis?

A. I would have thought that in general if you look at the work in the NHS I would see it as much more in general terms downstream of what you expect from MRC and the Wellcome Trust. To my mind they are complementary and that is why the Culyer Report is so fundamental, the recognition that there is a complementarity there.

813. You would prefer them to depend in a sense on the Concordat and similar agreements to that which the MRC has with the NHS?

A. I think the Concordat is an excellent mechanism which is, as I was seeing it in the MRC, developing very well. It needs, I think, particularly now, in the context of Culyer, to be seen particularly in two directions. I think the natural initial thrust was to ensure that MRC research took very strongly, to a greater degree than hitherto into account, the problems of the health service. I think now with the massive investment in basic research it is very important that the NHS R&D reflects the considerable commitment to basic research and the need to ensure that there is effective mechanism for

15 February 1995]

DR PETER DOYLE

[Continued]

[Chairman *contd.*]

exploitation because there is going to be a considerable change in the level of basic research.

814. You are aware that the Engineering and Physical Sciences Research Council just recently entered into a similar Concordat with the NHS?

A. Yes.

Lord Perry of Walton

815. I was going to ask what the current proportion—I am not talking of clinical trials, I am talking of basic pharmaceutical research—is now done in-house as compared to in the medical schools? How much do you invest in the medical schools as compared to doing anything in-house?

A. In the exploratory and basic research areas?

816. Is there any change going on?

A. There is a change because I think increasingly it is recognised that pharmaceutical companies are particularly good at pharmacologically based research but they are all accepting, by the way they are behaving, that as an add on to that there are now very exciting opportunities coming out of the study of human genetics which is a massive international programme where the United Kingdom I think has a very good position. All are recognising that you need access to all sorts of different types of expertise that is really of such a breadth that it is impossible to sustain in-house. You need a core of activity in-house so that you can recognise where the excellent centres are. We have, in common with others, established a core molecular biology/ biotechnology group but increasingly, and some companies have been much more higher profile than other's, companies go outside to academic centres and indeed to smaller companies. Say in the USA many people will go to smaller new biotech companies. In the United Kingdom, because of the excellence of the academic centres and institutes, more people will interact with them than perhaps biotechnology companies. It depends where you are in a national sense but everyone is looking outside much more than hitherto. It has been a massive trend over the last five years. Some people are dedicating specific amounts. We would not take that approach, I think we would say what is the quota to central research activities, what technologies and indeed research and potential products do we want to have access to, and therefore where should we be involved with both in the United Kingdom and in the USA particularly.

Chairman

817. Are you aware of companies, perhaps yourselves included, covering the service costs of, for instance, research beds or of research outpatient clinics, ie the revenue consequences of carrying out research?

A. I am assuming that these are all wrapped up in the total costs we pay for clinical trials.

818. I see. But it is something you would consider if it were necessary?

A. Yes. We have to accept that much as we might like to do everything on marginal costs that is an unreasonable proposition. We accepted that in

universities and I am sure that the health service would be equally keen that we accept the same principle.

819. What about indemnity and intellectual property rights?

A. We observe the ABPI guidelines in which we have a no fault compensation system for patients and volunteers involved in clinical trials which would come into effect when a causal link has been established. That means we have insurance cover for the individuals who are involved but that would exclude negligence on the part of physicians, etc.

Lord Perry of Walton

820. If you had an average new drug introduced, in practice how much is being spent overall by the time you get it on to the market?

A. I think the best and most recent calculation is somewhere between \$250 and \$300 million. That is an average cost taking into account success as well as failure which in real terms you have to, being realistic. You are looking at a cost for a major drug fully exploited on a worldwide basis probably over time of £200 million.

Chairman

821. Looking at the issue of publication, some concern has been expressed to us by research workers over the contracts entered into with Government health departments requiring communication before dissemination as it were, in other words requiring that the results of the research should be communicated to the Secretary of State before publication. Is this a requirement of research funded by pharmaceutical companies?

A. I honestly could not answer that. I can make the general statement that we are obviously keen to see publication and it is part of the agreements we strike with clinicians, an understanding that there will be a publication and that we will have the right to see what is published before it is published. In general we try to contrive a clear understanding that the publication will reflect the objectives of the study. There is always a discomfort if individuals go off down the track and do sub-analysis which may distract from the main message that is coming out of the clinical study.

Lord Butterfield

822. When I was involved with this I remember Hoechst took a big lead in saying that they would like to have sight of reports one month before they went off to the journal. That caused an air of astonishment among the academic world because they thought they would want six months to look at it. It was a reflection of the differences between your world and my old world. We have been worrying that fundamental and basic research is being crowded out by other kinds of research demands on the funds for research associated with NHS activities. You have twice indicated in your remarks that you think the funds for basic research, gene work and that kind of

15 February 1995]

DR PETER DOYLE

[Continued]

[Lord Butterfield *contd.*]

thing, are looking very healthy and that those who are in fundamental research should not regard themselves as on a loser but are probably on a gainer. Have you any idea of the sorts of sums of money that are going into basic research of the sort you are describing per year in this country now? Is it £100 million? What do you think it might be?

A. Thank you, Lord Butterfield. I am not sure that I had gone as far as that. I think I had indicated very substantial amounts going into basic research without arguing one way or the other whether they were sufficient. I have a simple view that basic research is fundamentally open-ended, it is a bit like costs in the health service, it is a potential black hole and one has to have sensible priorities. I think if I look at the tasks in hand, and I think in the area in which we are talking the possibilities in genetic research and in cell biology, developmental biology, have never been more exciting so there is a massive opportunity, that is leaving aside specialised areas like neuropathology and the central nervous system which are massive topics in their own right, the opportunities have never been greater and the tools to investigate that are all the more powerful. The opportunity to invest in basic research with an objective at the end of it has never been more exciting and more attractive. If you look at the size of the United Kingdom I think you would say that in the quality of our medical research and biological research in general we probably do very well considering the size of the country. I think we are fortunate to have both the MRC's research contribution and a comparable contribution from one charity and more from other charities. If you add up the totality and look towards assuming certain developments in pharmaceutical industry come to fruition, if you look at the potential for further investment in basic research I think there is a very considerable amount to go in. Those at the receiving end might say the task is such that even that is not enough but I think it is a pretty considerable slug. As I say, given that that considerable investment is going in I am particularly keen to see that some of the provisions in the Culyer Report are observed because they will give effect to that basic research.

Chairman

823. It has been suggested to us that basic research is being well provided for and that health service research, now under Peckham and the other activities relating to his department, is being looked after but it is clinical research, as it were, that has fallen between the two extremes and is being squeezed.

A. I think there is a general feeling in that area. I am not involved in setting up drug trials directly. I have now been directly out of the pharmaceutical industry for about six years but I collect a lot of anecdotal comments from people whose opinions I would give weight to and respect and if there is one common theme it is that there is a concern about the numbers and the quality of clinical research. If there is a theme that pervades that it is that very able and ambitious people who have got their sights on the most senior consultant posts seem to be reluctant to step off the ladder of advancement to take up the

fellowships that have been provided by the Wellcome Trust and the Medical Research Council. I think people would draw an unfavourable comparison, rightly or wrongly, between the culture that prevails in the United Kingdom and that which is in the USA where it is much more common to meet MD PhDs. You do meet these in rare centres, such as Professor Peters' area, but there are more isolated pockets where there is a much more common phenomenon to meet the doubly qualified person, if I can put it that way, in the USA. I do not have the precise numbers and I do not have really direct experience but the numbers of comments that go in the same direction are such that I would treat them significantly.

Lord Perry of Walton

824. Human genetics in biotechnology activity is a very big field and one that will attract a lot of money. I am slightly more worried about the small scale stuff that people start off with no idea as to where it is going to lead. The university basis of Higher Education Funding Councils does still provide for what they call well found departments. I am worried about the maintenance of well found hospital trusts. I am worried about what I think Culyer called the research facilities. As I read the paper I see much more emphasis placed on providing research facilities for health service research rather than for the clinical medical research. Are you worried about that?

A. Very much so. I think when I first came more closely up against the R&D in the health service what struck me was that it was an area of immense obfuscation. It seemed to me that with SIFTR and support for the London post-graduate medical schools, etc., there was great opportunity for frittering money away because no-one was very clear as to how much was going here or there and indeed what, when you had secured money, were the priorities and how they had been arrived at. It seemed to me that the Culyer Report was extremely timely in pointing out the need to gather together in a much more explicit way the funding stream for R&D. Once you have got your hands on that and some idea of what is spent you can then get a good view of how it is being spent and why. There are clearly two fundamental elements. One is to support the research that goes on, including the exploratory research referred to, and the other is to provide the very important service research which I think is absolutely essential. Key to getting effective spend of the research in the health service and for identifying where the priorities are is this making more explicit and having the national strategy and, above all, having a clear determination to implement the Culyer Report. We are tremendously good at grand strategy but we rather fall down on the implementation.

825. I very much agree. The single stream is fine but it is unlike a river, it is not fed by tributaries, effectively it is the opposite, it is breaking up into a delta.

A. Yes, it is.

826. What bothers me a lot is that I do not see any real control of the splitting of this stream. I am

15 February 1995]

DR PETER DOYLE

[Continued

[Lord Perry of Walton *contd.*]

bothered about that because the only things that Culyer suggests are for major committees and national committees but that is not how it works at the level of a hospital.

A. I think that is where I see the importance of two things. One is the redefined role of the CRDC which is providing a clear national strategy hopefully. I think it has been acknowledged that implementation has to be done through the regional directors of R&D. It seems to me that that is a very attractive model, that you have a clear central strategy but the way in which you effectively spend the money has to be through a more regional exploitation. You certainly cannot spend all of the, hopefully, 1.5 per cent from the centre, that would be a mistake to think you can, but I think you have to have clarity about the broad directions and let the specific directions be done through the regions so that some of the tributaries actually do get to the sea and do not dry up into a delta.

Chairman

827. Following this analogy of the river breaking up into a kind of delta, let us suppose you then have, as Culyer has recommended, an identified figure for the "R" component of SIFTR. Clearly some of that money is to be spent through Michael Peckham's department, through the central funding of research and development in the NHS. If you were sitting in his position would you wish to see that that "R" component was divided into two explicit streams, one for R&D and health service research at a central and regional level and another to support the excess service costs, the infrastructure, and the facilities required for the conduct of biomedical research at the periphery?

A. I think I would just want to see a broad distribution with the ability to be flexible at the edges. I think if you said it is 70/30 forever that would be wrong but I think you have to come out with a view that you are roughly going to spend two-thirds here and one-third there and watch to make sure that you do not hunt too far away from the centre otherwise you will drag money inexorably in one direction. I think it is very important to have a clear idea. It seems to me if you are going to have an idea of how you are going to divide that money, particularly if you are going to extend the Concordat principles and have a closer than ever and developing relationship with the research councils and with the charities, I think they have the right to see their basic research has a downstream component which will support the fruits of it.

828. You have said that you are not in a position to talk about the *modus operandi* of the CRDC because you have just joined it. Do you see the CRDC as having a major role in relation to the support of clinical curiosity driven research?

A. Yes.

829. Do you believe that the medical research community is producing enough clinical researchers of the quality which your company requires?

A. If I collect together all the anecdotal reports from beyond my company there is a real worry that we are getting enough.

830. You do not think you are?

A. Probably not.

831. So you are concerned about the future of academic clinical medicine?

A. Very much so.

832. And about the future of careers in research?

A. Yes.

Lord Nathan

833. It would be interesting to know why you think that is and what you think could be done about it. Is it the career structure?

A. I think you are in danger of getting me to try and come out with an expert opinion in an area where I am very non-expert. I think it is important that the royal colleges give the right sorts of signals about what should be the components of a career in that area. I do not think it is a lack of interest in the topic, nor probably fellowships to support it, I suspect people take signals from certain directions and get reluctant to step off a clear path to where they want to get to.

Chairman

834. Lastly, what do you think that the pharmaceutical industry is going to gain from the establishment of the National Forum?

A. I hope it will gain the opportunity to make such points as we have just been making about the importance of clinical research. I think it will give it the opportunity to put in a constant and strong message about the importance of the health service as a real test bed. I do not mean that in a sinister way. It seems to me it is the critical end of applied research in health care and medical research. There is an absolutely crucial role to be played. I think the health service to me seems to have certain unique advantages. I have certainly got very worried, particularly with the opportunities in genetics, about the importance of doing proper linkage studies, that the payer provider culture is actually militating against the free flow of information and samples in a very proper way. I think it is in the nature of research and all of us who have been involved in it understand there is an enlightened self-interest that pervades it in the sense that from time to time people will be asked to do things for other people that are not core to their own research programmes. There has always been a spirit wherever I have been in research of helping other researchers and never thinking of charging unless you get to something where it starts to become a project and then you have to be a little more formal. I think that informal interaction is part of the warp and weft of research. I actually know from colleagues that they are now seeking in the way they did hitherto information and perhaps samples and records to help them with their studies and getting the response "I am sorry, I have not got the budget or the time for that. You can have it but it will take so many days and cost such and such". If that culture comes in we have lost an enormous advantage from the health service, we really have. We have got tremendous advantages in the way that the health service is run

15 February 1995]

DR PETER DOYLE

[Continued]

[Chairman *contd.*]

from an R&D point of view and just when it is ever more important for the genetics approach to human health I think we are in danger of losing that. That is touched on, of course, in various reports.

Lord Perry of Walton

835. We have talked about clinical trials, how do you select the general practitioners to help? There must be very, very different qualities in the help you are getting from them.

A. I guess in the majority of our trials for a new drug we will be looking at hospital specialists, these will be the consultants generally in the teaching hospital environment. I am trying to think where you get into post-marketing studies you may then draw in a broader population of general practitioners but most of our multi-centre trials will be done through hospitals and specialist units.

Chairman] Thank you very much, you have been very good to spare the time. We have found it very rewarding and helpful to us in our enquiry.

Memorandum submitted by Professor J D Swales MA, MD, FRCP

I am currently head of the Department of Medicine in the University of Leicester. The Medical School at Leicester was a new one, which took its first students in 1975. Establishing the Department of Medicine therefore involved setting up an academic group with responsibility for teaching and research in poorly funded district hospitals. At present the Department has seven professors and approximately 30 academic staff in several sub-specialties of hospital-based internal medicine. In addition, I have been Chairman of the Association of Clinical Professors of Medicine and of the Federation of Associations of Clinical Professors. I have served on grant-giving committees of a number of bodies which fund medical research and I am currently Chairman of the Chairs and Programme Grants Committee of the British Heart Foundation. This is the senior policy advisory committee of the largest funding body for cardiovascular research in the United Kingdom. I serve on the Central Research and Development Committee of the NHS and chaired the Expert Advisory Group on Research Priorities in Cardiovascular Disease and Stroke. I also chair the Trent Regional R & D Strategy Council.

I do not think it is possible to address the specific issues of concern to your committee without briefly mentioning the long term problems of medical research which confront advanced countries. These arise from the very success of science, its growth and the potential for exponential increase in the applications of science to medical practice. As a result priority areas have to be defined either explicitly or implicitly. The second point which is fundamental, but nevertheless often overlooked is that the new, enormously successful molecular sciences have not replaced the traditional fields of organ based physiology and clinical research. This is particularly true now that molecular biology is beginning to throw light upon the major polygenic, disabling and killing diseases, such as diabetes, ischaemic heart disease, stroke and cancer. This is an argument eloquently put forward by Ahrens in his book "The Crisis in Clinical Research". Biomedical research is critically dependent upon careful definition of the clinical picture (the "phenotype") and pathophysiological changes in individual organs in order to dissect out a disturbed process which may show important differences between individuals apparent only on clinical assessment. Clinical research in the patient has assumed greater rather than less importance as a result of the success of biomedical science.

The third and last factor at work is the growth of health services research. The clinical research community mainly educated in biochemistry and physiology have tended until recently to estimate this fairly lowly. It did not attract many high grade academics and applications for funding were in the main of low quality. The obvious mismatch between potential need and resources available has led to increased concern over efficiency and effectiveness of prevention and care in the health service. As a result of the NHS R & D Strategy and initiatives by for instance the MRC, there is much more high quality research at this more applied end of the medical research spectrum.

The needs which have to be met

Apart from direct funding, it is clearly necessary to have funding of the infrastructure costs and personnel to carry out the research. The difficulty in developing an adequate career structure for clinical scientists has been endlessly discussed over the past decade or two without satisfactory resolution. Partly this reflects the difficulty in reconciling a specialist career structure in medicine with equally specialist training in science. The tensions here are continuing to grow. I have progressively come to the view that some of the problems here are due to a failure to define the science. This accounts for the frequently heard statement that clinical scientists may be "diverted" by too much clinical work or training needs. This is unquestionably a problem in laboratory-based biomedical science where protection from clinical service is needed: the failure of the NHS and colleges to provide adequately for the needs of such individuals is a source of concern. At the same time, patient orientated or health service research often requires fully trained clinicians. To take an example, one group in Leicester were interested in whether a particular gene predisposed patients to restenosis (ie

15 February 1995]

[Continued]

failure) after coronary angioplasty, a topic of great importance to the Health Service. This required high level expertise at the laboratory and clinical end, with two very well motivated clinicians with strong academic background, one a University Senior Lecturer and one an NHS consultant, both of whom have invested a large amount of time and labour in the work.

I believe therefore that research at the more applied, clinical end requires a large body of adequately trained well motivated clinical scientists who are at the front of their specialty as well as dedicated to the pursuit of science. The numbers have to be large and it is undesirable to concentrate them in a few select centres, although clearly leadership may need to be more focused. Appropriate case mix, and group size is important in the study of the heterogeneous, common multifactorial diseases. This is quite different from the perceived need for laboratory based biomedical research which requires more critical mass concentrated in select laboratories.

My comments on the NHS R & D programme and the Culyer Report follow from the above analysis.

Infrastructure Funding and the Culyer Report

The obstacles to clinical research are formidable even when a motivated clinical researcher has a high quality project: he has to secure funding usually from an external body and ethical committee permission. He also has to secure approval (if the work is carried out in a hospital) from his Trust. The Trust may object on grounds of time and resources. My work for the British Heart Foundation requires me to chair site visits to holders of British Heart Foundation Professorships in the majority of Medical Schools. Trust Chief Executives in general describe the high value they place upon research, but it is clear that in the internal market they neither have the funds to support the indirect costs in some cases, nor are they prepared to allow too much staff time to be devoted to it. The result is a serious constraint upon clinical research, even by those academics not funded by the Trust, where contribution to the clinical service is not paid for by the host institution.

I strongly welcome therefore any change which protects infrastructural funding. I have however a number of concerns:

- (a) The present use of the R element of SIFTR is obscure, but it seems likely that it is being used to support the clinical service. If so, there are obvious dangers in establishing a separate stream. I suspect that this fear is more apparent than real as any trend in this direction would probably be met by recalculation.
- (b) Potentially the central funding of the infrastructure costs of projects funded by the NHS, charities or MRC requires a separate assessment system. This would comprise a significant extra hurdle in an activity where there are already major deterrents.
- (c) There is a strong tradition of small pilot clinical studies carried out by clinicians before formal funding is sought. Most of the studies of for instance dialysis with which I was associated 30 years ago were of this sort. This type of work is often responsible for significant later clinical development. A rigid system of assessment and funding of infrastructure costs would tend to destroy this.
- (d) There is a danger of worsening of what has become a two-tier system for clinical trials. The pharmaceutical industry makes a major investment in both the direct and indirect costs of trials, as part of the licensing procedures for drugs and are therefore in a relatively privileged position. Assessment of other forms of patient management requires direct funding by the NHS, charities or research councils. Restricted availability of infrastructure costs inevitably produces a further limitation on such trials. This is a major problem which already exists of course not merely in this country, but internationally. It has important consequences for the NHS. To take one example: there are a number of large extremely expensive multi-centre trials of cholesterol lowering drugs taking place, in the main funded by industry. Over the next few years we will have an excellent assessment of their efficacy. On the other hand, the evidence of efficacy for dietary regimes in lowering cholesterol is patchy and controversial. The same contrast is observed with dietary and pharmacological means of lowering blood pressure. It could be argued that this difficulty will exist whatever the system adopted for funding indirect costs. The problem nevertheless is likely to become greater if infrastructure costs become even more rate-limiting than they are. The effectiveness and success of the NHS is not necessarily always served by the development of new drugs rather than other modes of management.
- (e) The idea of core-funding based upon an assessment exercise is useful if it emphasises to health service managers the needs of R & D. I am more concerned if the processes become sufficiently Draconian to remove some major institutions from the clinical research scene altogether. Once removed it is difficult to see how they could return. This would be disastrous for the development of what I believe essential—the creation of a wide research culture in the NHS.
- (f) The need to develop research in primary care is essential. I welcome the Culyer proposals in this context, although it lies outside my field of expertise.

15 February 1995]

[Continued

The NHS R & D Programme

Professor Peckham's programme has unquestionably had a beneficial impact in raising the awareness of R & D in the NHS and funding potentially valuable work. My own direct involvement has been with the Cardiovascular Disease and Stroke Programme. In setting the priorities of this programme it became apparent how much of a learning experience was required—not least by the medical research community who had great difficulty in some areas in escaping from accepted ways of thinking and in attaching importance to such concepts as "value to the NHS".

More specifically, I would make the following comments.

- (a) Internal departmental pressures resulted in unrealistic deadlines for expert groups and for invited research.
- (b) The same internal pressures have generated an extremely wide ranging and ambitious programme of research in priority areas which outstrips the resources devoted to it. The Health Technology Assessment Programme, which attempts to cover all areas of medical activity is a case in point. A more restricted pilot programme to assess the best approach in such an innovatory strategy would I feel have been more appropriate but clearly not acceptable when political pressure to obtain results was so intense.
- (c) A major feature of the programme was that consumers and purchasers of health care should have a major input into commissioned research. In the consultation exercise in which I participated, for the Cardiovascular Disease and Stroke Programme and from my experience as a member of the CRDC, I am not convinced that this has been particularly successful. Neither of these groups appeared familiar enough in scientific method to throw much fresh light on research needs.
- (d) The R & D programme was heavily dependent on Regional Directors of Research and Development. Although doubts were expressed initially about this, it has in the main worked well. I am a good deal less optimistic about Regional Directors working as civil servants in regional offices covering substantially greater areas. The great advantage of the Regional Directors was that they were in the main respected members of the academic community with close contacts both with the local NHS and academic community. This will be much more difficult to achieve with the new arrangements, which I argued against on the CRDC. It should not be forgotten that the clinical research community in the main obtains its funding of direct costs from outside the NHS. If the NHS is perceived to be remote and bureaucratic, the temptation will be to move into fields of research which are not dependent on NHS support. If that happens it will be a great tragedy for both parties.

Examination of witness

PROFESSOR JOHN D SWALES MA, MD, FRCP, Professor of Medicine, University of Leicester, was called in and examined.

Chairman

836. Professor Swales, thank you very much indeed for coming. If I may say so, we are very grateful for your paper which you have provided for us on medical research and the NHS reforms which we have found extremely helpful. I must say there was one point that I picked out which you highlighted and which is emerging I believe from many aspects of our enquiry and that is that clinical research on the patient has assumed greater rather than less importance as a result of the success of biomedical science.

(Professor Swales) Thank you very much.

837. You may, if you so wish, introduce yourself and give perhaps a little more detail to your background.

A. Thank you very much indeed. My background is fundamentally as a Professor of Medicine in a new medical school, the last of the new medical schools, in Leicester. This really involved setting up a full academic infrastructure in what was a very poorly funded group of district general hospitals. That was done in 1974-75 before our first students came. Since then we have built the department to a fairly large one covering the majority of sub-specialities of

medicine. Subsequently I have been involved with the British Heart Foundation and I am Chairman of the Chairs and Programme Grants Committee which is their major policy advisory committee. I have been a member of the CRDC and chaired their Cardiovascular Stroke Research Priority Programme as well as their Cochrane Centre Review Committee. Also as part of the work of Michael Peckham's department I have chaired the review committee for Hammersmith Hospital at the time of the Thompson Review of SHAs. Briefly, I have dipped my finger in a number of pies.

838. Thank you. Your view of the current standing of United Kingdom clinical science?

A. I think this is a difficult area where there are many hard opinions but relatively few hard facts. I think one can look at it from a number of points of view. If one looks internally within the United Kingdom in terms of recruitment there is clearly quite a problem. Anecdotally senior lecturer posts are particularly difficult to fill even in the more attractive fields of medical research. The BHF decided as a matter of policy three or four years ago that they would appoint two or three new professors of cardiology a year with some of the reserve funds

15 February 1995]

PROFESSOR JOHN D SWALES

[Continued]

[Chairman *contd.*]

which were available at that time. Since then, two years ago we interviewed and appointed one, none of the other candidates were of adequate standing, last year again we appointed one and interviewed one, and we are interviewing one, having had only one applicant, later this month. There is, I believe, a significant shortfall in these very prestigious and very well supported academic opportunities. I do not think the same thing is true at the bottom of the ladder. We still have many very enthusiastic young people who want to enter academic medicine but as they proceed up the ladder what we get are significant losses. That is, as it were, the internal evidence within the United Kingdom. I think recruitment is probably one of the best measures of that. If one looks externally I think there have been two studies which are germane to this issue, one slightly more direct than the other. In 1990 Stossel published a study in the *New England Journal of Medicine* on the source of papers in leading clinical research journals in the United States. It is very interesting that the background to this was concern that the standing of clinical research in the United States was declining, so the problem is by no means peculiar to this country. It did indeed show that there was a decline in the contribution of papers from the United States to those lead journals and they were being replaced by papers from abroad. I think the significant thing is the source of those papers from abroad which was Japan and some of the countries of Western Europe. Where they specified individual countries the United Kingdom was not participating in that general invasion of clinical research in the United States. There is a second and much more direct study of this which was published by the Philadelphia based Institute of Scientific Information in 1992. They looked both at the volume of research in a variety of scientific specialities and also the citation impact. I think one has to be cautious in one's interpretation of these data. The United Kingdom did quite well in terms of volume of publications in clinical research, but of course this is a fairly non-discriminatory sort of measure. It includes, for instance, the whole gamut of literature on case reports and clinical reports which are not fundamentally medical research. It is rather as if you were putting together studies in basic botany with flower collecting papers, the two things are very different. When they came to look at the impact of papers, who was actually citing papers and how many of these publications were being cited by other workers, they showed a steady decline in the proportion of papers in clinical research in the United Kingdom compared with many of the other areas of science which they looked at. Since about 1988/89 this had been occurring. Their article on this was headed "Critical Condition: Clinical Research in UK Fading Fast". This was a progressive and quite significant decline, up to 30 per cent in some sub-specialties. I emphasise that was an independent body, certainly with no axe to grind in this field. It was American based, and fairly damning in its conclusions. I think that is probably the best objective evidence we have that there seems to be something specifically amiss with the impact of clinical research from the United Kingdom compared with some of the other advanced countries.

839. What would be your solution to the crisis of recruitment in academic and clinical research?

A. To address that question one has to say what does one mean by clinical research? Who is one trying to support? There are really two separate communities of medically qualified people who are essential for the health of clinical research in the United Kingdom. One group are what you might call the professional academics, largely university based people whose career is in either biomedical or clinical research. Their career structure at the moment I think is a very uncertain one and the attractions of moving on to NHS practice or private practice are very great. I also think—and this is critical in this day and age—that one should be encouraging a research culture much more broader than that small group of people. I tried to allude to the arguments here in my paper. Perhaps I could say there are three reasons for saying this. Firstly, as biomedical science progresses it is now moving from the relatively straight forward monogenic single gene disorders to the large causes of morbidity and mortality like heart disease and cancer. The monogenic diseases are relatively simple by comparison, they can in most cases be diagnosed in a test tube. The major diseases require much more close definition of the phenotype, of the clinical picture. For instance, I mentioned the study which we have just finished which is just about to appear in the *Lancet* looking at the failure of angioplasty, which is dilatation of the coronary arteries, in patients with angina or after a myocardial infarction. About 30 to 40 per cent of these operations fail and there is a strong suggestion that this is genetic. Now, if one is investigating this one requires very careful definition of the reasons for failure: is it technical; is it due to these genetic causes? That requires angioplasty, it requires careful interpretation of angioplasties. To do this type of work you need a much larger group of people than the small academic body of people available. You have got to have interested, involved clinicians who are motivated to carry out research and to ensure that there are not the obstacles to those carrying out that research. It is also the case that many of the biomedical processes which we are looking at now generalise across a number of diseases. In our field we are moving from hypertensive vascular disease, for instance, to diabetic vascular disease, so that the science base is much more broad than we can cope with. Lastly, there is the development of health service's research which involves the setting up and the assessment of health services and health service systems. I think, to answer your question directly therefore, there are two needs here: in the professional academic community we have to ensure, and partly this is the role of the colleges of course but it is also a question of the general ambience in which people work, that there is an adequate, defined career structure for those people. I think we also have to ensure, however, that the broader community of people working within the health service do not have substantial obstacles to their continuing involvement in research. I think this second group of people is just as important as the first.

840. What effect do you think the Calman Report and its implementation is likely to have on the training grid?

15 February 1995]

PROFESSOR JOHN D SWALES

[Continued]

[Chairman *contd.*]

A. I think we still have to wait for the full impact. It could be beneficial in many ways: a shorter period of training for doctors, the incorporation of a period of training in research uniformly would actually help to encourage this culture. What I fear about the Calman Report is that it is being introduced without additional funds. The changes in the hospital staffing structure are going to throw a greater service burden, particularly on more senior members of the staff, and if that is not coped with by an adequate increase in numbers then those service burdens are going to impede the development of research. I have considerable fears in that direction.

Lord Perry of Walton

841. You talked of removing the obstacles to the non-academic clinician doing research. I can think of three, I wonder whether you thought of the same ones: the pressure on managers to do more patient care; there is the attraction of private practice in some cases; and there is possibly also the fear that doing that kind of research will not attract distinction awards in the same way as perhaps just looking after more patients.

A. I very much agree with those arguments. One of my duties in the British Heart Foundation is to carry out site visits of their Chairs. They have about 15 Clinical Chairs and a number of other basic Science Chairs. I think I have visited now virtually every academic unit of cardiology in the country. We always like to hear from the chief executive of the Trust. I am now fairly accustomed to the statement, either verbally or on paper, that "we are strongly supportive of a research culture in our hospital and we will do all we can to support that" but then the word which always occurs, "but we have no funds for this either direct or indirect support of research and we have a very heavy clinical service burden to bear". I think the pressure of service work output is top of the list. I think the question of distinction awards is very variable from one institution to another. I think in some teaching hospitals the role of research is recognised fully and this is accepted in the culture of some teaching hospitals but this may not be true everywhere.

Baroness McFarlane of Llandaff

842. How dependent is your medical school on NHS funded posts?

A. Like many provincial hospitals we are very substantially dependent on them. More than 50 per cent of the clinical academic posts in our medical school are funded through the NHS. They are funded in the main through NHS trusts and not through the regions which I believe is slightly different from many other institutions. Clearly the viability of the institution depends on these.

843. Are these under threat at all?

A. They are not under threat at all at the moment but of course one does not know if funding change how far that will be the case.

Chairman

844. But if the Government is committed, as they say they are, to increasing the consultant establishment, would it be your wish to see increasing numbers of academic posts, let us say at senior lecturer level for example, to help to contribute to the problems that you have suggested now exist in relation to academic recruitment?

A. I think that would be extremely valuable, so long as an excessive service burden was not placed upon those senior lecturers. After the last House of Lords' Report 50 new senior lecturers were funded, not by the NHS but by the UFC as it then was, and those 50 new posts have proved extremely valuable, certainly to us and to many other departments as well.

845. What about SIFTR? Do you anticipate any problems when 25 per cent of SIFTR is diverted into the new R&D funding stream?

A. If it is done without careful monitoring of the consequences then I think eventually it would cause very considerable problems to the institutions which currently receive it. In the hospital in which I work the research component adds up to about £2.5 million out of a budget of about £100 million. Much of this is, of course, used in the running of the institution and not actually in support of research. I am sure this is true of most teaching institutions in the country. To remove money in that way without carefully monitoring the consequences could have a disastrous impact on the solvency of these institutions.

Lord Perry of Walton

846. Did you say £2.5 million was SIFTR?

A. It is part of the "R" component of SIFTR.

847. The "R" component. And the £100 million was?

A. The total budget of the hospital.

848. What is the total SIFTR including the teaching element?

A. That will come to about £10 million.

849. Ten out of 100?

A. Yes.

Chairman

850. Do you see any merit in the idea that I put to Dr Doyle of perhaps dividing the "R" component into two streams, one for the support of R&D in the broad sense and in the sense of health service research and the other for the support of biomedical research and facilities?

A. I think that is extremely important because I cannot see the funds for supporting the indirect costs of research coming from any other obvious source. A lot would depend on how it was done. One can imagine a bureaucratically nightmarish operation in which clinical research projects had to be assessed, not only for their scientific validity by the funding body but also by the R&D Directorate for indirect costs.

15 February 1995]

PROFESSOR JOHN D SWALES

[Continued]

Lord Perry of Walton

851. 75 per cent of SIFTR is supposed to be for the support of teaching and as we all know teaching ought to happen in a research environment, but I have heard other people say that most of this "T" element is actually spent on research support. Do you agree with that?

A. I think it is almost impossible to assess how the money is spent. This is one of the problems that we have. The activities of the teaching hospital are very well integrated, clinical service and teaching are particularly closely integrated and in some cases teaching can actually accelerate patient throughput: in outpatients, for instance, if one allows students to take on cases. I think actually disaggregating those costs is an exercise which has not been done properly.

Chairman

852. Do you see any justification for the view that has been expressed to us that the "R" component monies should be at the disposal of a committee which would include not only the Regional Director of Research and Development but also the Dean of the medical school or his nominee and representatives of hospital trusts? In other words, should the university be involved?

A. I think the university is critically involved. It does provide most of the people doing the research in most cases. I think at some level university representation is critical, yes.

Lord Perry of Walton

853. It is also argued sometimes that the real "R" component is only two per cent because two per cent was added to the total when "R" came in and not 25 per cent. Would it be better if instead of taking 25 per cent, which is arbitrary, one only took the two?

A. I think that in the absence of information of how much is required to support a viable body of research one cannot really pluck figures out of the air and say "This would be satisfactory" or "that would be satisfactory". My gut feeling is that when these figures are disaggregated there will be insufficient to support much of the mainline clinical research that is going on. That is simply a gut feeling, there is no hard evidence on this at all. I think as the Culyer system begins to bite we do require much better assessment of the indirect costs of research in order to do this and the sorts of budgets that will be necessary to support it.

Lord Nathan

854. Professor Swales, you refer in your memorandum to "the need to develop research in primary care". As a very lay Member of this Committee I am very conscious of the fact that traditional research in the medical context is the prime matter for consideration but that patients are now sent out of hospital after having their hospital treatment as a result of what might be called the traditional form of research and find themselves in the community where they are supposed to get care and therefore the burdens seem to have shifted to some extent from the hospital to the community. I

was wondering what your thoughts were with regard to research in the context of primary care bearing those points in mind. We have heard something about this but not very much. How much has actually been done in this field? How is it organised? Who is in command? This may be outside your special province but I could not avoid the possibility of taking advantage of your being with us.

A. I speak very much as an outsider to the field but I do serve on funding bodies both nationally and in the region which often look at research in primary care. My views might be slightly heretical. I would certainly not like to speak for the primary care research community in this. One thing is clear and that is the need for research in primary care. One of the reasons I suspect that we get away in this country with paying so much lower a proportion of our gross national product on health care and still have quite a reasonable health system is the existence of very strong primary health care as a gate to the secondary care system in this country. I think a lot depends on primary care in that sense. It is therefore unfortunate that there is so little research data actually of quality emerging from primary care. That would be one point. The second would be that the nature of research in primary care is rather different from the sort of research that most of us have been brought up in, either biomedical or clinical research or some combination of the two. It is very much at the health service's end of research, very much about educational research, with improving levels of care. This is a thing with which many of us older established people in the research community are slightly uneasy with. It requires a rather different sort of approach. I think it needs encouraging. There are clearly very substantial questions and difficulties in dealing with a very independent group of people with no established tradition of infrastructure funding. I would not dare to specify how those problems could be dealt with, I can simply recognise the importance of the problems and the need to deal with them. There is a need to appreciate the philosophy of primary care research which is rather different from the sort of philosophy that I was brought up in.

855. Does it come under the Regional Director of R&D and if not who is responsible in that sense for the establishment of research programmes in this field?

A. I do not think they differ in terms of potential support from what we might call mainline clinical research. Clearly there are university based academic departments of general practice funded with difficulty but by traditional procedures. There certainly are regional initiatives. We have one in Trent, for instance, recognising this need. We earmarked £275,000 towards the development of the infrastructure of research in primary care. We had no idea, and I think this is perhaps a good example of current uncertainties of how this was going to be used, so we took the traditional approach of throwing it open to bids from outside. We had a very strong bid from a consortium of largely academic departments of general practice with an excellent programme of developing infrastructure for research in general practice and we are now proceeding with this. Again, there is no reason why charity support of general practice research or Research Council support should not be forthcoming.

15 February 1995]

PROFESSOR JOHN D SWALES

[Continued]

Chairman

856. And of course the general practitioners are able to apply to regional locally operated clinical research funds. It has been put to us by the representatives of the general practitioners that we saw that two mechanisms which they have found to be of value are, first, a mechanism whereby certain practices may be designated as research practices with funding, say, from either the kind of initiative that you have mentioned or even from the Royal College of General Practitioners, or that individual general practitioners might be paid for research sessions from the "R" component. Of course, up to the moment primary care has not benefitted from SIFTR, has it, so it does need a new mechanism. How can we keep alive the tradition of small pilot clinical studies carried out by clinicians before formal funding is sought?

A. As I noted in my memorandum, the obstacles to research and the formalisation of research support are now very formidable indeed, even without considering the Culyer proposals. You have to get ethical committee permission, you now have to get permission from your trust because there is a question of indemnity and you then of course have to get direct support. This takes time, it takes formal project design protocols, yet much of the research one knows was not actually developed in that way, it consists in a small number of studies on one or two patients leading towards developing a protocol and then going for outside funding. There is obviously a conflict here between the needs of accountability for funding and the needs for flexibility. This is a thing we see in many areas of course. Perhaps I can just outline what we have done about this at the British Heart Foundation where we have the strength of a certain amount of reserve funds and we recognise very much the need for this non-protocol driven research. What we have done for the past year is to give the professors of cardiology, supported by the British Heart Foundation, ten per cent extra on every grant which is given to their department, either for one of their senior lecturers or for themselves, without any strings attached to the money at all. Quite substantial amounts, several hundred thousand pounds worth have already been given in this way. There is a degree of accountability in that we have regular site visits and clearly we will be asking how that money is used on these regular site visits. Could I also say perhaps that I think the question is even broader than you suggest. I think we are not simply involved with early studies, we are also involved with what you might call early people. In other words, you have clinicians who may want to enter an academic career, may want a period of research. The funding bodies like them to have some sort of experience below their belt to make sure that they are doing the right thing. I am sure this is true of the Wellcome Trust fellowships, the MRC fellowships, the British Heart Foundation fellowships. In some hospitals endowment funds are used for this purpose. Certainly the majority of provincial hospitals, including my own, have very little in that way and to secure non-earmarked money for people as well as projects is, I think, equally important.

857. Is this not one of the objectives of the locally operated clinical research scheme which has been in existence at the regional level?

A. I think it is. I think our problem at the moment in Trent is we fund 16 out of 160 of those projects although we are maintaining the strength of the scheme. The funding is very limited, however.

858. What do you feel about the danger to which you referred of a "two-tier system for clinical trials" with drug companies paying the full costs, and the charities and others paying only the direct costs of trials of non-pharmaceutical treatments which might then be increasingly restricted by the limits on NHS service support?

A. I think this is an extremely important issue, my Lord Chairman. I think one thing is clear from my experience in the British Heart Foundation and I believe it is also true of the other medical charities although I am sure they can speak for themselves, that the charities will not be willing to pay indirect costs of research. It means under the Culyer system that potentially the funding of indirect costs could become a rate limiting operation for research in these areas. That clearly is undesirable in many ways. I think it also reveals hidden distortions in the system which have concerned me for some time in that the greater part of heart and cardiovascular research in this country, for instance, is funded by the British Heart Foundation. It is difficult to disaggregate funds but probably about two-thirds to three-quarters of cardiac research is funded by the BHF. I am sure the cancer charities fund the greater part of cancer research. If you say they are going to be limited by this problem with indirect costs, whilst for instance a separate mechanism along the lines of the Concordat works with MRC funded studies, we are going to introduce a distortion in which research into these mainline areas is to some extent more limited than research in other areas. I think that is highly undesirable.

859. Would it not be possible to argue in a sense that the ten per cent extra of British Heart Foundation funding which you are giving on grants at the moment is rather like the implicit funding of teaching hospital overheads which Culyer wants to pull out?

A. We hope not, my Lord Chairman. We specifically exclude funding of overheads from this, it is funding of preliminary experiments and people.

860. Could you tell us about your involvement with the review of the work of the Cochrane Centre?

A. Yes. As part of the continuing support of the Cochrane Centre I was asked to chair the Review Committee. I have no doubt you have access to our report which was strongly supportive of an initiative that is potentially important and I think unique really. We still are in the early days of the support of the Cochrane Centre, there have been no outcomes yet. The major work associated with it was completed—that is the Perinatal Database—before the Department of Health took over the funding of the Cochrane Centre. Potentially it has a very big role to play in the development of a scientific understanding of clinical care of patients. I come back perhaps, if I may, to my original point. The meta-analysis, which is one of the major techniques applied here, is potentially a dangerous technique in

15 February 1995]

PROFESSOR JOHN D SWALES

[Continued]

[Chairman *contd.*]

the wrong hands. It is enormously powerful at amplifying conclusions but it can also amplify error and bias. By pooling studies together you are still always at the end of the day left with an uncertainty as to how far your conclusions on the pooled data can apply to each individual study. For instance, if you pool old and young people together, or different means of lowering blood pressure, say, you may get an overall effect. It may not apply to old people or to young people, you just have to look at the data and be sure. I have a very good example of this. I have occasionally lectured on meta-analysis and I used to use the example of magnesium in myocardial infarction and early studies showed a 25 per cent reduction in mortality. The meta-analysis was carried out which confirmed that. A further study, which happened to have been carried out in Leicester, also confirmed the meta-analysis and everyone was happy. We had one of these marvellous meta-analyses graphs to show the progressively greater significance of benefit. Then a study which was under way which was far larger than all the rest of them put together was put in and the position moved from net benefit to net harm with simply one study. There are all sorts of explanations for this but clearly at some stage an error had been amplified. I think one needs the clinical acumen, the trained clinical research approach, to interpret the results even when you have got such a powerful tool in your hands.

861. Why are you concerned about the Health Technology Assessment Programme?

A. I think concern may be a little strong, my Lord Chairman. I think there are certain criticisms of it. One is its very extent. It took as its definition any form of medical intervention and treatment, technology, surgical procedures. That seemed to me to be rather a broad definition. As a result of that it overlapped quite significantly with the other fields of commissioned research by the Department of Health. In my own field most of the priorities which are established in cardiovascular disease and stroke are related to interventions. Thirdly, I think in the enormous initial list of priorities, well over one thousand priorities which they came up with, there was a failure to distinguish between existing knowledge and the need to review it and the need for new knowledge. I think that was inevitably part of the way the Committee works, with a very large body of data like that. I think it could have been a little more in depth.

862. Also it should have concentrated in your view on a fewer number of interventions?

A. Yes.

863. You are anxious in the CRDC that the new regional director posts should be part-time rather than whole time. We wonder whether the fact that those who have now been appointed, the five new ones, are whole time has in any way reduced your concern?

A. I do not think it has, my Lord Chairman. Five have been appointed, one only on a temporary basis and is to leave, I believe, towards the end of this year. Three of the others were in fact a continuation of full-time posts and only one was, as it were, a newcomer

to the scene. My concern was the relationship with the clinical research community. This is central. They are, after all, not in a position of line management with the Department of Health in most cases, they are people who are funded by external bodies and who have a considerable degree of independence. Whilst we hear a great deal about selling research to the purchasing authorities, and I would agree with that, we hear very little about the need to sell NHS programmes to the clinical research community. There have been some fairly spectacular examples of the failure to understand it. There was one in the *Lancet* a couple of months ago in an editorial where a very leading clinical researcher showed a complete lack of understanding. I think with the reorganisation of the health service, with the reduction to eight regional offices, the incorporation of the R&D post really into the Civil Service, there is a danger of remoteness from the people working on the ground. This had been recognised in the case of post-graduate deans who have developed much closer links with the universities but it does not seem to have been the case with the R&D directors. I think there is a real danger of them being perceived to be remote and of the NHS being perceived to be a potential obstacle to desirable activities but not perhaps as a stimulator of activities.

864. You may like later to tell us perhaps briefly in writing what you think about the work of the CRDC Cardiovascular Disease and Stroke Programme and also your views on the Trent Regional R&D Report and Prospective Plan. Just finally, concern has been expressed to us about contracts between health departments on the one hand and various units in the NHS on the other which have required notification before dissemination, in other words the contract requiring the results of the research should be reported to the Secretary of State before being published. Any views?

A. Yes, I would be very concerned. In the Trent region we discussed this and we do not have any such clause in the research contract. It is reasonable to have a delay clause built in and some pharmaceutical firms do in fact have one so that they do have the opportunity of looking at the conclusions and perhaps even discussing the conclusions with the researcher. I think, as was mentioned in the previous witness's evidence, a month is quite acceptable. I do not think indefinite delays should be introduced into the principle of publication, I think this would go against everything that the academic community believes.

865. Thank you. We are all accustomed in the universities, at least I think this is still the case, that before submitting a research grant application, for instance for a research grant to the MRC, that you are required to consult the university authorities to make certain that the requirements for the infrastructure of that research are there and the details given on the salary scales and so on are proper and correct. There is a suggestion now from Culyer that there should be a similar requirement that research fund applications be looked at by the NHS authorities before submission. What is your view on that?

15 February 1995]

PROFESSOR JOHN D SWALES

[Continued]

[Chairman *contd.*]

A. I think it would introduce one more obstacle to develop research. I think the trust should accept that applications which have gone through the recognised machinery are acceptable. There is a separate question of indemnity which has still not been properly resolved but I think in terms of adequate funding infrastructure this should really be taken on trust if the applications have gone through the established recognised machinery.

866. I see. If it has gone through the established machinery it has been submitted through the university. Are you then suggesting that the university might consult the executive of the trust to see whether the clinical facilities needed are available?

A. I would hope that under the Culyer system the funding body will also have access to funds for the funding of the indirect costs of the research. So,

assuming the work has been funded by a charity or by the MRC then it should be accepted that the indirect costs have actually been funded as well.

867. That is your view. So you would not wish it to be signed off by the NHS authority either on submission or on acceptance?

A. It might require it on acceptance but I would be a little concerned about putting another obstacle in the way of applications for funding if this could possibly be avoided.

868. So acceptance would be something that you would not object to?

A. No.

869. I can only say again thank you very much indeed for sparing the time to come and talk to us. Your comments have been extremely helpful.

Letter from Professor Swales

As I mentioned to you in my previous letter I do not think I have a great deal to add about the NHS Cardiovascular Disease and Stroke Commissioned Research Programme. I believe that it has been successful as is shown by the very large number of applications both for the first round and for the second round that is now underway. I was very impressed indeed by the expertise and care exerted by Michael Peckham's staff in support of this programme. The only two points of substance I would make are that for budgetary reasons we had to work to a very tight deadline. This of necessity curbed our discussions. Secondly, the consultation exercise worked well with bodies and individuals who are used to framing and discussing research questions, but consultation with many lay bodies yielded a response which was difficult to convert into fields of research. A more interactive process would have been extremely valuable. We embarked upon this briefly with a single workshop to which interested individuals were invited. This proved extremely useful but time considerations prevented us taking this approach any further. Subsequent Priorities Committees have organised more workshops to help the consultation process.

Lord Walton also asked me to submit in writing on the Trent Regional R & D Report and Prospective Plan. Since its institution I have been Chairman of the Trent R & D Research Strategy Council and involved with the production of this plan therefore. At Trent RHA we have been fortunate in having a Health Authority that is strongly committed to the support of research. We have the disadvantage perhaps of two new medical schools with little in the way of endowment funds available for the support of research. Trent funds therefore assume even greater importance. Our philosophy has been to change the balance of research in the direction of applied health services research. This however I must emphasise has not been at the expense of basic biomedical research and indeed funds in support of this latter activity have been somewhat increased over the last two years. However, extra money has been put into health services research to fund such new developments as the Trent Institute for Health Services Research and the Primary Care Research Focus to which I referred in my evidence. Finally another major thrust of our strategy has been to support the infrastructure of research through fellowships. We have deliberately spread the type of fellowship offered very broadly. Relatively small sums of money are offered for short courses and training whilst a number of full-time health services research fellowships have been offered at the other end of the spectrum. As I intimated in my evidence the basic philosophy has been to improve the broader culture of research within the Trent RHA borders and to increase the number of "professional" academics with an interest in health services research. The scheme is too early to monitor any outcomes but the take-up rate has been extremely encouraging.

20 February 1995

MINUTES OF EVIDENCE
TAKEN BEFORE

**THE SELECT COMMITTEE ON SCIENCE
AND TECHNOLOGY**

**(SUB-COMMITTEE I MEDICAL RESEARCH AND
THE NHS REFORMS)**

Tuesday 21 February 1995

CONFERENCE OF MEDICAL ROYAL COLLEGES

*Professor Sir Leslie Turnberg, Sir Christopher Paine,
Professor Cedric Prys-Roberts and Dr William McN Styles*

**NATIONAL ASSOCIATION OF HEALTH AUTHORITIES
AND TRUSTS**

*Dr C J Robinson, Professor J B L Howell, Mr S Thornton,
Dame Margaret Turner-Warwick, Mr M Else, Dr A G Morgan
and Mr D J Moss*

Printed pursuant to the Order of The House of Lords of 22 November 1994

LONDON : HMSO

£6.65 net

TUESDAY 21 FEBRUARY 1995

Present:

Butterfield, L.	Perry of Southwark, B.
Flowers, L.	Perry of Walton, L.
Gregson, L.	Walton of Detchant, L.
McFarlane of Llandaff, B.	(Chairman)
Nathan, L.	

Memorandum by the Conference of Medical Royal Colleges and their Faculties in the UK**SUMMARY**

We strongly support the emphasis placed on relevant high quality and timely research and development to improve the nation's health. We welcome the recommendations that funds for R&D and for its service support be separated from other funds, that primary and community care sectors should compete on an equal footing with the acute sector, and that the method of funding should be by placing a levy on purchasers.

We have the following concerns about the ways in which the proposals will be put into practice:

- (a) **Types of Research and Peer Review.** A single funding stream for R&D could lead to a narrow view of the criteria for research and might stultify innovation. There should be a balance between science-driven and needs driven research.
- (b) **Funding Identification and Re-assignment.** Research activities which are currently successful should not be threatened; this is particularly important in teaching hospitals and in the London special health authority hospitals. To avoid damage, the pace of change should not be rushed.

Placing decisions on funding in the hands of a small number of directors of R&D will cause tensions unless those directly concerned in research can be involved in any proposed changes.

- (c) **Directors of R&D and Research Skills.** The eight regional directors of R&D should be senior figures of academic repute who also have managerial skills. If their expertise lies predominantly in management, rather than research, the R&D initiative will lose credibility with the research community. It is vital for adequate peer review mechanisms to be set up.
- (d) **Assessment and Appraisal.** While accepting the importance of assessment, it is equally important that these exercises do not consume more effort than the research itself.
- (e) **Public Health and Epidemiological Research.** The omission of specific mention for research into public health and epidemiology should be repaired.
- (f) **Career pathway for R&D Researchers.** It is vitally important for the R&D initiative to pay particular attention to the need to foster training and career pathways.
- (g) **Composition of Central R&D Committee.** As this Committee is already large, increasing it by including purchasers and providers is unlikely to be efficient and productive. It is suggested that a small central committee with a number of subgroups would be more effective.
- (h) **Register of Research.** The size of the task of maintaining this register is perhaps under-estimated.

We wish to make the following additional comments:

- (a) **Health Technology Assessment.** We support this assessment being pursued under the R&D Directorate's initiative. There is also a need for assessment of new procedures and the Medical Royal Colleges are willing to act as assessors for the NHS.
- (b) **The Cochrane Centre** is an important initiative and should be strongly supported.
- (c) **Tertiary Referrals in the Internal Market.** Much clinical research is dependent upon sufficient numbers of relevant patients being referred to centres of excellence and the internal market appears to be inhibiting the referral of such patients, thus interfering with research.

1. The call for evidence lists three areas of interest to which the sub-committee is seeking a response. Those listed under the first item relating to the NHS Research and Development (R&D) strategy are linked to the second item on the Culyer Report. We have, therefore, brought these two together in our response.

2. We are strongly supportive of the emphasis placed on relevant high quality and timely research and development to improve the nation's health and the quality of health care. The recommendations to separate funds for R&D and for its service support from other funds; to ensure accountability; for a national strategy; and that primary and community care sectors should compete on an equal footing with the acute sector, are all very welcome. The method of funding, by placing a levy on purchasers, is entirely appropriate and we are strongly supportive of this mechanism. It would be important to ensure that this levy is placed on all

*21 February 1995]**[Continued]*

purchasers, including fundholding general practitioners, who are set to hold an increasing proportion of the NHS budget.

3. The report provides a picture of general principles but inevitably there are anxieties about how the principles will be enacted in practice. Our concerns are:

(a) Types of Research and Peer Review

While there are considerable advantages to greater clarity of the funding for R&D, the focus into a single funding stream brings with it the danger that this may lead to a narrow view of the criteria for research.

For example, NHS purchasers will wish to see results of research in terms of short-term benefits to the NHS; and single large committees developing their own ideas and agenda about what research to support could potentially stultify innovative approaches.

The current multiplicity of funding groups does allow unorthodox approaches which, in the past, have been the forerunners of major advances (eg test tube babies, artificial hips, both of which arose out of the main stream of recognised teaching centres). It will be important therefore, in the portfolio of R&D support, that sufficient attention is provided in the current market for a balance to be maintained between science-driven and service needs-driven research. While the Research and Development Directorate will be seeking bids for research in areas they identify as being of importance they should also be open to proposals put to them from the research as well as the service communities.

It will be vital for adequate peer review mechanisms to be set up to ensure that only high quality research is supported (ie that research which will be capable of yielding valid, reliable and applicable results).

(b) Funding Identification and Re-assignment

The identification of all funding currently used for R&D, with the implication that this will make its use more transparent, will help in the process of increasing accountability. However it will be important not to impair currently successful research activities by threatening their existing funding. There is some fear in teaching hospitals and in the London special health authority hospitals that identification of the R of SIFT(R) for the former and of the special funding for research for the latter, may be shortly followed by the removal of their infrastructure monies. The 25 per cent of SIFT(R) identified in this way is arbitrary but much care will be needed in its withdrawal and re-assignment. The postgraduate hospitals in London are at particular risk from both the withdrawal of their infrastructure funding and their introduction into the market. If we are not to lose this important element of the nation's research capability special care and attention will have to be taken over this. The input of those directly concerned will be vital to these deliberations.

While identification of these elements of funding may be important it will be critically dependent on the directors of R&D as to how they judge where this money will be best spent. Placing such important decisions in the hands of a relatively small number of individuals is likely to cause considerable tension, unless there is a process by which those directly concerned can be involved in any proposed changes. This is likely to be of particular relevance to university hospitals where a proportion (up to 45 per cent) of academic staff are supported on NHS SIFT(R) funding. This element has allowed the evolution of academic departments, particularly in geriatric medicine, psychiatry, radiology and anaesthetics to the considerable advantage of the Health Service. The sensitivity needed to deal with the identification and potential withdrawal of the R of SIFT(R) is emphasised by this example.

(c) Directors of R&D and Research Skills

The R&D programme will be overseen by eight regional directors of R&D who will, therefore, be in a powerful position, particularly as they are to be members of the Regional Executive. This authority places on them considerable responsibility and it will be vital for these posts to be occupied, as at present, by senior figures of academic repute who also have managerial skills. If in the future, there is a tendency to appoint directors whose expertise lies predominantly in management, the R&D initiative will lose credibility with the research community whose vital contribution would be placed in jeopardy. The report draws attention to the lack of research capacity in the professions allied to medicine. But there is also a lack of research skills in the practising medical profession at large. Academic medicine has a vital role, therefore, in education, training and research design as well as execution and should not be discouraged from contributing to the exercise.

(d) Assessment and Appraisal

It is right and proper that there should be an assessment at intervals of the R&D activities being undertaken and of the facilities under which they are occurring. The academic community is now used to the research selectivity exercise of HEFCE. They recognise that this is a major undertaking consuming considerable time and effort. It is vitally important that these assessment exercises do not consume more effort than the research itself. The frequency of assessment exercises should be such as not to interfere with the process and five or seven yearly intervals would be infinitely preferable to three yearly exercises.

*21 February 1995]**[Continued]**(e) Public Health and Epidemiological Research*

There is a welcome focus of attention on the need to encourage research in the primary and community setting, but surprisingly there is little or no mention of the need for research in public health and epidemiology. This is an omission which should be repaired.

(f) Career Pathway for R&D Researchers

Mention is made of the lack of career paths for many working in R&D within the NHS but the report itself suggests that this is not directly within its terms of reference. However, it will be vitally important to ensure that the R&D initiative pays particular attention to the need to foster training and career pathways, otherwise the initiative is likely to fail.

(g) Pace of Change of Re-assignment of R&D Funds

There is some concern about the pace at which the changes will be introduced. Some can be introduced rapidly but others, particularly where there is a need to identify existing funding and consider its reassignment, should not be rushed. The danger of dramatic switches to existing high quality research is alluded to above.

(h) Composition of Central R&D Committee

It is suggested that the Central Research and Development Committee should be re-cast to include more NHS purchasers and providers and key commissioners of R&D such as higher education institutions, industry, research councils and charities. The CRDC is already a very large committee and on the practical level it is unlikely that such a major increase in the size of the group will be productive. As a committee of perhaps 20 individuals is much more likely to be efficient and productive, a rather better mechanism than that proposed might be to see a small central committee with a number of sub groups comprising the various interests.

(i) Register of Research

The task of ensuring adequate liaison between the CRDC and the regional committees and the maintenance of a national register of research is attractive, but the size of the task is perhaps under estimated. We wonder how up-to-date such information will be in practice.

4. In summary, we commend the principles of the Culyer proposals but urge caution in the ways in which these principles will be put into practice. It will be vitally important for the academic research community to play their full part in the NHS R&D programmes and in order to maintain their enthusiasm they will need to have the reassurance that good research, capable of yielding valid results, will not be disturbed during the transition and that the move to diffuse research across a broader field will not result in a poorer overall end product.

5. Many of the topics suggested in the list of subjects raised by the sub-committee in their corporate evidence are covered in the above comments. A number, however, remain.

(a) Health Technology Assessment

We are strongly supportive of the principles involved in the programme of Health Technology Assessment being pursued under the R&D Directorate's initiative and headed by Professor Miles Irving. The need for such an appraisal process is clear. In addition, there is also a need for appraisal and assessment of new procedures undertaken in surgical and other practical disciplines such as endoscopy and angioplasty. This falls outside the technology assessment programme and the Medical Royal Colleges are willing to take on the role of assessors for the NHS.

(b) The Cochrane Centre

Is a very important initiative and is undertaking important appraisal of clinical trials. The work is long and arduous and rapid results should not be expected. We believe it has the potential to provide very important benefits to the NHS and should be strongly supported. We are not yet sufficiently confident that the York Centre will be of similar benefit.

(c) Tertiary referrals in the internal market

This is a matter of considerable concern. Much clinical research is dependent upon sufficient numbers of relevant patients being referred to centres of expertise where the research is undertaken. There seems little doubt that the internal market is inhibiting referral of such patients and is interfering with research as a result. This highlights the need to ensure that the SIFT(R) funding of teaching hospitals takes sufficient account of the need to encourage such referrals by allowing them to maintain their competitiveness for such patients in

21 February 1995]

[Continued

the internal market. There is also the fear that competition leads to an unwillingness of trusts to share information which might be of advantage to a competitor. This in turn has an impact on collaborative research between centres and of clinical trials which are commonly of such type. The potential impact on our research productivity should not be underestimated. Indeed, one of the important attributes of research in the UK has been this facility to undertake multi-centre research which is now threatened.

19 December 1994

Examination of Witnesses

PROFESSOR SIR LESLIE TURNBERG, President, Royal College of Physicians and Chairman, Conference of Medical Royal Colleges and their Faculties in the UK, SIR CHRISTOPHER PAINE, President, Royal College of Radiologists, PROFESSOR CEDRIC PRYS-ROBERTS, President, Royal College of Anaesthetists, DR WILLIAM MCN STYLES, Chairman, Council of the Royal College of General Practitioners, were called in and examined.

Chairman

870. Good morning, gentlemen. Thank you very much for coming and being willing to talk to us.

(*Professor Sir Leslie Turnberg*) Thank you very much indeed for allowing us to come before you.

871. What is your assessment of the NHS R&D strategy as it at present stands and, in particular, what do you think about the priority setting exercises of the Central R&D Committee and the Standing Group on Health Technology?

(*Professor Sir Leslie Turnberg*) If I can start, in general we are impressed by the NHS R&D strategy. We like the idea that it is putting research and development on the agenda of the trusts, the purchasers and the NHS executive, and that it is involving all the professions and involving them in a much more accountable and open way. We believe that it is particularly important to emphasise what the R&D strategy does emphasise, that good practice is dependent on good research evidence. So we are very supportive of the general principle. We are concerned to some extent about the way in which priority setting is gone about and, in particular, we are concerned about the mechanism by which the R&D committees centrally and regionally go about their business of deciding on their priorities for research. Sir Christopher Paine, who is here, has been involved I believe in one or two of these and might wish to comment.

872. You might also wish to comment on what you see as being the advantages or potential disadvantages of the Culyer proposals relating to the restructuring of the Central Research and Development Committee and what you see as the role of the National Forum.

(*Sir Christopher Paine*) Could I deal with the point that Sir Leslie brought up first. I have been involved with just one of the current exercises, actually choosing topics for cancer research which the R&D executive put out. We went through an elaborate series of meetings to do this, some of them quite widely based and more or less open to the public, at least to professional people. I simply felt at the end of that exercise we perhaps might not have grasped the detailed points where research was likely to be productive. All sorts of good ideas were put forward and real deficits in knowledge were explored but perhaps because the group was such a wide group we did not focus on the areas which we could really do something about. It turned out to be a list of things that were more theoretical than practical in some

ways, I thought. That was the point I wished to make. I suppose the other point is that there was a hurry about it. One had a few months within which to do this. There was not really quite enough time, I feel, to obtain specialist advice in order to come up with a series of 20 proposals and six important ones which were really the things we ought to be focusing on. It was too much of a hurry to do that properly. The idea, I think, was a good one and we learnt from it and no doubt those involved in other such exercises would have also.

Lord Gregson

873. How well co-ordinated was it with other bodies like the Cancer Research Campaign and charities and universities and the Medical Research Council? Is it fully integrated into that sort of situation?

(*Sir Christopher Paine*) All of those bodies were represented on the group that considered this. Half a dozen people were doing the work and we had meetings and all of those groups were fully represented. I do not think there was any problem there. The sheer breadth of trying to produce six priorities to the nation in cancer research was quite difficult to do within the timescale that we had.

Chairman

874. Has it been followed up by any kind of practical on-going development in relation to research into cancer?

(*Sir Christopher Paine*) It will in due course, my Lord Chairman. After the priorities were agreed advertisements were put out for good projects to come in and that process is going ahead. Professor Peckham would know more about that than I do. I think contracts for some projects have been let. Of course, if you do this it takes a long time before one sees results because it is a matter of control-led clinical trials and their outcome.

875. Is there a particular form of research or area of research which you would regard as being best suited to this type of central approach?

(*Professor Sir Leslie Turnberg*) I suppose the sort of research which is best directed is that which is going to be disseminated out and about in the community. I suppose for that which is right at the coal face of primary care and community care there is a need, I think, in those circumstances to ensure that there is not a lot of diffuse type of research effort over which there is little influence. That can diffuse funds;

21 February 1995]

PROFESSOR SIR LESLIE TURNBERG, SIR CHRISTOPHER PAINE,
PROFESSOR CEDRIC PRYS-ROBERTS AND DR WILLIAM MCN STYLES

[Continued]

[Chairman *contd.*]

it can diffuse ideas and it may not produce the best end result. I think directed elements for that are important. You asked a question about the restructuring.

876. Of the CRDC and the National Forum.

(*Professor Sir Leslie Turnberg*) I think my impression is that there will be a very large central R&D Committee which will have quite a large proportion of purchasers, providers and others with an interest in research. There is a danger, I think, that those who have to direct the research and those who have research experience will be dominated by the service need rather more than the balance I would like to see, which is in favour of those who have a direct interest and involvement in research. I think there are two problems; the first is the size of the central R&D Committee and the second is the drive by those concerned more directly with research and research ideas.

877. And the Forum?

(*Professor Sir Leslie Turnberg*) I am afraid I cannot answer that.

Lord Perry of Walton

878. On page two of your written evidence, at the top of the page, you say: "It will be vital for adequate peer review mechanisms to be set up to ensure that only high quality research is supported (ie, that research which will be capable of yielding valid, reliable and applicable results)." There is much high quality research that does not yield any applicable results and I hope you would change that to "or applicable".

(*Professor Sir Leslie Turnberg*) I think the word "capable" is the operative word. When you start a piece of research you at least should have an ambition that it will be helpful in advancing knowledge or in having some application. If there is no hope of that you might as well not start.

879. I quite agree, but advances in knowledge may not be applicable, so if you said "yielding valid, reliable or applicable results" I would be much happier.

(*Professor Sir Leslie Turnberg*) Yes, I accept that.

Chairman

880. Professor Peckham has told us that the NHS R&D funding budget is no longer "enslaved" by the target figure of 1.5 per cent of the total NHS spend. Do you consider this to be too little or too much or have you any idea about what would be a better figure?

(*Professor Sir Leslie Turnberg*) I suppose there are two aspects to this. One to 1.5 per cent is quite a small proportion of the total budget to be spending on R&D. In big organisations such as the NHS it would not be over spending at 1.5 per cent on R&D considering the extent of the exercise. In general terms it is certainly small. The second point relates to what has been done with the 1.5 per cent we are putting in at the moment. I think there is a feeling that we do have to see some effectiveness demonstrated for the input thus far. I do think that if we are to spread the research particularly into

primary care and community care and into areas where there has been little research, if we are to do that and take it from existing good research, that is potentially damaging. If we are to extend the net and increase the range of research which is undertaken under the NHS umbrella then it will be necessary to increase the amount. I could not tell you how much.

Lord Flowers

881. You said you thought that 1.5 per cent was modest, you implied that?

(*Professor Sir Leslie Turnberg*) Yes.

882. If you take national averages of GNP or something one gets slightly higher figures in countries like ours but the fact is, what successful individual industries and activities spend may vary widely from less than one per cent to as much as three per cent. I think one needs something rather more specific by way of argument to say that 1.5 per cent is always not okay.

(*Professor Sir Leslie Turnberg*) I agree with that comment hence my slight proviso saying I wished to see demonstrable effectiveness for what we are already doing. That will not be immediately available. I have a fear in the interim phase when we are changing the way research is undertaken spreading into areas which hitherto have not received research funding there is a potential for damage to those areas which we already do support. I think that transition which we refer to in our document is going to have to be very carefully managed and has to involve a very careful assessment of existing research as well as that which is intended.

Lord Butterfield] As a matter of fact, Sir Leslie has just said what I wanted him to say which is that we should protect what we have got and not destroy it in a drive to spread over the wider field as the money is dispersed. I am delighted with his remarks.

Baroness McFarlane of Llandaff

883. It has been put to us that curiosity driven research is under threat because of the pressures of the internal market. It has also been put to us that a new emphasis on health services research, which this Committee encouraged in 1988, has been taken too far by both the NHS and the Medical Research Council to the detriment of clinical bio-medical research and we wondered what your views were on this.

(*Professor Sir Leslie Turnberg*) Perhaps I can comment first and then Professor Prys-Roberts will fill in some of the detail. I think obviously there is a matter of balance and a careful judgement about how far one should move away from the bio-medical side towards the NHS service side. The emphasis on health service research is certainly there. I do not think we have yet evidence that we have moved too far in that direction. I think there is plenty of room to go because at the moment there is not as much health service research I suspect as we would like to see. That is not to say we should damage bio-medical research in trying to achieve this end as I hinted. I think there is so much importance to this balance. If I can give an example: I was at a meeting at our College last week at which a demonstration of some

21 February 1995]

PROFESSOR SIR LESLIE TURNBERG, SIR CHRISTOPHER PAINE,
PROFESSOR CEDRIC PRYS-ROBERTS AND DR WILLIAM MCN STYLES

[Continued]

[Baroness McFarlane of Llandaff *contd.*]

new therapy for rheumatoid arthritis was discussed which involved the use of the anti-bodies against tumour necrosis factor, an inflammatory mediator which produced dramatic results in reducing inflammation in people with arthritis. And it was an amazing revelation at that time. Of course there is much to do before they can put that into general practice. There is a lot of research needed but that sort of development in rheumatoid arthritis seems equally applicable to other forms of inflammation such as bowel disease and lung disease. If it were to come in, as a result of curiosity-driven biomedical research, it would have a major impact on the need for all those services in which research in the NHS is going on, better wheelchairs, better support facilities for people crippled by arthritis; that will all be markedly influenced by the results of the biomedical research. There is a balance to be struck and we cannot afford to lose the advances on the bio-medical front taken into clinical practice. We cannot afford to neglect that in order to do the other research. They both have to be done, so it is a matter of balance.

Chairman

884. It has been suggested to us that since Culyer has recommended that the R component of SIFTR should be put into a single stream of funding for the support of research in the NHS, that this, in turn, may mean dividing them into two; one part of the R component may be devoted to health services research and R&D in traditional terms, and another part to support the infrastructure and facilities needed for biomedical research. Do you have a view to express at this suggestion?

(*Professor Prys-Roberts*) Yes, we do have a very distinct view because what has happened in the interim phase of the development of this new R&D process is that the locally organised research schemes which, in many ways, were extremely successful—although some people would say it was difficult to identify areas where they have produced major advances in what is now known as health service research—they have fallen by the wayside and this is part of the imbalance which Sir Leslie Turnberg was referring to. There has not, as yet, appeared to be at the regional R&D level a re-emergence of the same degree of funding. This applies very much to the infrastructure of NHS departments who are doing research, and also to the clinical departments in universities who are doing research and who were getting a lot of their funding from locally organised schemes. I may say that I appear almost wearing two hats in that I was also responsible for chairing the SCOPME (Standing Committee on Postgraduate Medical Education) report to your Lordships on this process, and we noted that whilst there was a desirability for going for a research rating technique such as that used by the Higher Education Funding Council and using this also in the assessment of both the curiosity-driven and also the health service-driven research, that it is important that such ratings should not be the only thing which was responsible for that type of funding, particularly where the infrastructure was responsible. So we need to maintain a constant infrastructure support while

adding or subtracting over and above that on the basis of research ratings.

885. Do you wish to comment on the continuation of the locally operated research schemes once the regions disappear?

(*Professor Prys-Roberts*) Although the regions in themselves might disappear, they will be coalesced into larger units and one finds it difficult to see how they can function without being subdivided into some form of system, probably based on the existing regions, in which case the existing regional R&D directors will have a very big responsibility for ensuring that there is a continuation, particularly of the curiosity-driven research, which is so important in the clinical field.

Lord Perry of Walton

886. I am, like all of us, extremely worried about the career prospects for clinical academics in the major medical schools. Although Sir Colin told us that in internal medicine branches there was only a very small recruitment problem, we were also told by the Dean of the Faculty of Medicine in Edinburgh that he was facing losing or reducing the number of lecturers in clinical departments from 46 to 16, with a swingeing effect on the whole of research and teaching in the clinical departments. Would you like to comment on what the situation is, because I cannot see anything in Culyer which suggests what measures can be taken.

(*Professor Sir Leslie Turnberg*) I think, first of all, I can confirm that this is a major problem—recruitment into academic medicine. At least, in part, it is due to the reduction in the number of career opportunities at the end of a period in academic medicine. A lecturer may be tempted in because of the interest he has in research, but if there is nothing at the end of it all in terms of a senior lectureship or a permanent career grade post, then there is a problem. That seems to be one of the major disincentives to those in the medical disciplines, particularly in Medicine. In other disciplines there is another problem. In anaesthetics, in orthopaedics, psychiatry, radiology, there is not so much a problem of lack of posts at the top end, but there is a failure of people to go into these academic disciplines because of the attraction of being able to go rapidly through the system into a consultant's post and perhaps undue accentuation of the need to pass exams at the end of it all. So the training programmes will, in some instances, provide disincentives to those who might go into academic careers. The problems are; in Medicine, as Colin Dollery suggests, a lack of openings at the top end, and I am not sure what one can do about that. In the other disciplines, I suspect there is rather more we can do through the R&D initiative to encourage people, during their training periods, and perhaps by reducing the rigidity of the programmes to encourage people to enter the academic ladder.

887. Do you think one way out of it could be, for instance, to regard senior lectureships, which carry honorary consultant status as wholly supernumerary to establishments and pay them out of funds for facilities—basic facilities in the service?

21 February 1995]

PROFESSOR SIR LESLIE TURNBERG, SIR CHRISTOPHER PAINE,
PROFESSOR CEDRIC PRYS-ROBERTS AND DR WILLIAM MCN STYLES

[Continued]

[Lord Perry of Walton *contd.*]

(*Professor Sir Leslie Turnberg*) I think many universities and medical schools have up to 40 or so per cent of their clinical academic staff funded on research infrastructure and on NHS R&D type funding. There is a fear that that element will be increasingly threatened as the R&D funding becomes much more transparent, particularly when the R of SIFTR goes from what it is used for. There is a threat to those particular types of posts which do offer an avenue for academics and we have to pay particular attention to those.

888. That is, with great respect, the diagnosis of the problem but I still do not have a treatment.

(*Professor Sir Leslie Turnberg*) I think it is extraordinarily difficult. I think it is a possibility that the Wellcome Trust or the MRC, for example, or other large research charities, might be encouraged to fund posts at the top end for periods of time—five or ten years—or for longer term posts. The R&D Initiative might focus on that too. This would encourage entry at the bottom end.

889. Is the unified clinical training grade going to make matters even worse in terms of clinical jobs for academics?

(*Professor Sir Leslie Turnberg*) I think that the way most programmes are organised, they do not pose a disincentive for people to take time out to do research during their training. That is, most programmes encourage periods of time out. Mobility will not be the problem. But I think there are problems in that there are considerable attractions to young trainees to go through a short programme and then embark straight away on an NHS career with no blocks along on the way. It is against that sort of attractiveness that the academic community will have to try to compete. That may pose problems.

Chairman

890. It has been put to us that the regions and some districts paying for academic posts out of NHS funds has not so much been a charge against R&D, but has been a strategic mechanism for developing specialties which have been in need of that academic development and thereby providing better service. Is that one of the things you would accept as being the major reason?

(*Professor Sir Leslie Turnberg*) I think it is. The old regional health authorities, out of self-interest, to try to bolster the level and quality of service would fund academic departments, or academic posts, and I think that has been successful. They have borne fruit.

Lord Perry of Walton

891. When R was added to SIFTR the money made available went up by 2 per cent. Would it help if that was regarded as the R element of the total SIFTR budget rather than 25 per cent?

(*Professor Sir Leslie Turnberg*) It would be unrealistic. It would not be a realistic assessment of the proportion of SIFTR which is used as research activities.

Lord Perry of Walton] You could argue that 100 per cent of SIFTR was involved in research and teaching.

Chairman

892. It has been suggested that the unified training grade under Calman will only allow one year out to undertake research which is surely insufficient for the aspiring academic?

(*Professor Sir Leslie Turnberg*) That is not quite correct, because a trainee will be given a number on entry to the grade. They can take that number with them for periods of three or more years. When they step outside the clinical post, they keep the number with them. This is a disincentive to the department which releases someone to take that period out for research, because the department or the unit will not be able to fill that post with a numbered trainee. They will have to fill it with an overseas doctor, a trainee from another country, who would not be expected to take up some of the manpower calculations.

893. They would only be able to fill it with a visiting registrar?

(*Professor Sir Leslie Turnberg*) Yes.

Baroness Perry of Southwark

894. You were talking about the 40 per cent of posts which are attributable now, to one form or another, of R&D within medical schools. You said that when the R element in SIFTR became more transparent and the R factor had to be accounted for more precisely, then some of these posts might be under threat. That rather implies, does it not, that some of these posts are being paid for out of other budgets currently or, in the past, were paid for out of other budgets. What were these budgets? Where was the money coming from if it was not coming from the R factor or other clearly definable sources for research? What other budgets were contributing to it?

(*Professor Sir Leslie Turnberg*) First of all, I ought to correct something. I may have given the impression that all medical schools have 40 per cent of their clinical academic staff supported in that way. The proportion varies enormously between medical schools. Some have a very small proportion, others more, but I do not think there are any who are more than 40 per cent or so. As far as the source of that income, it has always been extraordinarily difficult to tease out where that money comes from. Indeed, it is extraordinarily difficult to tease out where SIFTR has gone or what it is used for. The total of SIFTR would easily cover this, so you could say that SIFTR was predominantly used in those universities for this purpose. One would then not have to define some alternative source.

Chairman

895. Is it not however the case that in many instances a regional health authority may have decided for health service purposes that it needs, say, a new consultant in dermatology but it recognised that dermatology in that region may not have had a high standing in a professional sense and therefore instead of appointing a consultant it gave the money to a university to appoint a senior lecturer or professor to develop that discipline, anticipating that that individual would still give the services that the consultant would have done.

21 February 1995]

PROFESSOR SIR LESLIE TURNBERG, SIR CHRISTOPHER PAINE,
PROFESSOR CEDRIC PRYS-ROBERTS AND DR WILLIAM MCN STYLES

[Continued]

[Chairman contd.]

(*Professor Sir Leslie Turnberg*) You are absolutely right. There is a down side to all of this and the down side is that the appointees under this funding source may be expected to deliver a much greater service load and furthermore they may not contribute greatly to the academic well-being of the university to which they are appointed. They may not contribute to the research side so there is a potential for this sort of funding to be misused in academic terms even though in NHS service terms there may be considerable advantages.

896. Thank you. We have seen several regional R&D plans produced by regional directors and presumably you have seen them as well. Do you want to single any out for praise and blame?

(*Professor Sir Leslie Turnberg*) We have not seen many, one or two of us have seen one or two plans but we do know of one or two plans which include the development of general practice research centres. We have felt these have offered considerable advantages and a potential for good research being provided at that sort of level. We are very supportive of that.

(*Dr Styles*) I think that is something that from a general practice point of view we very much welcome. I think particularly south and west England—the plan I know that has taken that forward—and in my own region, North Thames, there has been a great emphasise on research training programmes. From a general practice point of view we would welcome those sorts of developments. Those are the only two regional plans I have information on.

Lord Flowers

897. Would you permit me to go back to SIFTR for a moment. I wonder whether it is possible to spend SIFTR in such a way as to attract as much external income as possible so you get large gearing. I do not know whether that is the attitude that is adopted towards it or whether one just says, "Thank God we have got some money; let's spend it."

(*Professor Sir Leslie Turnberg*) I think that is a valid point; that the R element should be used in a way to support people who are doing good research. In those cases where it is obviously being used to good purpose, I think the idea that there will some sort of research assessment, or that account will be taken of what other income is generated rather like the HEFC exercise is a valid way forward on that. It will bring in an element of funding in areas where there is an attraction for others to follow.

898. Is the system such that you could regard it in that gearing sense?

(*Professor Sir Leslie Turnberg*) At the moment it is not; I think the plan is that it will be.

899. Thank you.

(*Sir Christopher Paine*) Could I make one point, my Lord Chairman, on regional plans. As the regions become larger and coalesce we must, I think, be sure these regional plans remain relevant and sensitive to smaller projects. One or two I have seen are quite general in their terms and excellent things are supported but I am worried it may not be sufficiently sensitive, particularly to the curiosity driven research which we have mentioned earlier and to the smaller

health service research projects which are important and I think to get through this planning process we must not create another bureaucracy at that level.

Lord Gregson

900. Are you really suggesting the thing is too top-down and not enough bottom-up in effect? It sounds a bit top-down to me quite frankly.

(*Sir Christopher Paine*) I think, my Lord Chairman, there was nothing at the top before and perhaps it is just as well there is something there but on the other hand there is a risk, as always in this country, we set out with a good intent and ensnare ourselves in a bureaucracy that does not achieve too much. I think at the moment some of these regional plans are very good and as long as the point is taken with the regions enlarging there must be a mechanism for good projects to get through quite quickly then I am satisfied but I think there is a risk we need to be aware off.

Chairman

901. Yes, the regions are enlarging but the regional health authorities are due to disappear. There will be a regional office of the NHS management executive. Are you then suggesting that that office with the regional director of R&D should be the avenue through which, for instance, the locally operated clinical research schemes should continue?

(*Sir Christopher Paine*) There will need to be something closer to the grassroots I suggest, my Lord, because I think they are going to be too distant. Nevertheless the regional director of research is going to be the animal of the Central Research and Development Committee operating at that level, therefore he must be sensitive to smaller lower down schemes.

(*Professor Sir Leslie Turnberg*) I think this emphasises the critical importance of who the research and development directors are and what their credibility is in the academic community at large. I think it is going to be vital they are of the calibre and type that we have currently amongst the R&D directors who come from a strong academic base, who can understand when projects are put to them from the grassroots and have been involved in assessing projects of that type. I do think if we continue with similar people we will be all right. The danger may be if in the future R&D directors move from being true blue academics into being managers of research activity and primarily civil servants rather than academic researchers.

Lord Gregson

902. Does it not also depend on some degree of peer review? When you start talking about individuals I get a little bit worried about dictators.

(*Professor Sir Leslie Turnberg*) I think a lot will depend on the R&D directors. There will be eight of them. They are going to be key figures. They will obviously have to develop good peer review mechanisms. It cannot go on without it.

21 February 1995]

PROFESSOR SIR LESLIE TURNBERG, SIR CHRISTOPHER PAINE,
PROFESSOR CEDRIC PRYS-ROBERTS AND DR WILLIAM MCN STYLES

[Continued]

Chairman

903. For that reason would you prefer that the appointments should be part-time or whole time?

(*Professor Sir Leslie Turnberg*) My own preference is for part-time. I think there is a danger we may not get sufficiently high calibre individuals going into these posts if they had to give up everything else in order to do it.

904. How would you wish to see them appointed?

(*Professor Sir Leslie Turnberg*) I would wish them to be appointed by a committee that involved strong university and academic representation on the appointments committee and they should retain a foothold in the academic camp but a part-time one.

Lord Butterfield

905. We have been interested to read the proposals for dividing up the R&D programme into the three customer groups. I do not know if you remember the report that has come out quite recently in the last two months suggesting there is going to be a strategy which will incorporate public health research, basic research and research into services particularly for children and women. Have you begun to grapple with the impact of that on the kind of things that we are worried about too, namely how that system is going to take care of the curiosity driven research which I think it is fair to say most of us round this table feel is the actual root from which it all stems in the end? Have you become aware of that and have you begun to probe to find out how that is going to work at the new regional level?

(*Professor Sir Leslie Turnberg*) I think you have put your finger on a very important point of how one preserves the ability to undertake good curiosity driven research in a system where all the funding is controlled from above. I think it reflects closely on a previous question about how one ensures there is a facility for input of good ideas into this R&D body and it is the balance between directed research and research that arises from individual initiative at the grassroots. I think that is going to be very tricky. I think there has to be a root to the R&D directors and to the committee for ideas to be submitted rather than expect the central committee at regional level to produce all the R&D ideas itself.

Lord Gregson

906. Is that a case for the application of the Rothschild principle?

(*Professor Sir Leslie Turnberg*) Yes.

Baroness Perry of Southwark

907. I was interested to see at the end of your memorandum that you expressed concern about the results of increased competition on people's willingness to share information. I wonder if you would like to elaborate on where your fears come from and whether you have any evidence already as to whether that has begun to happen.

(*Professor Sir Leslie Turnberg*) Thank you very much. It is extraordinarily difficult to get that sort of information because by its nature people do not wish to share information on things which they do not wish to share. I think it is quite hard to find examples. We did come across one or two in relation to the

sharing of audit protocols. One trust I know developed quite good protocols for auditing gastrointestinal haemorrhage, and they were quite reluctant to let those protocols be shared by nearby trusts. They thought they were doing very well with it. I think this is very much a fear because of attitudes. It is quite difficult to get examples.

908. Can you explain to me in what sense they were doing well with it?

(*Professor Sir Leslie Turnberg*) The medical staff thought it was a good system of auditing how they went about treating their patients with gastrointestinal haemorrhage. It was rather a fear in the executives of the trust that they would not wish their nearby trusts to have a similar system that they had not evolved themselves which they had invested in.

909. That seems pointless.

(*Professor Sir Leslie Turnberg*) I agree.

Chairman

910. That seems very curious and contrary to the ethos of medicine---

(*Professor Sir Leslie Turnberg*) I have to say in the end the results were shared but it took a delay.

(*Professor Cedric Prys-Roberts*) My Lord Chairman, there is a very good example of the opposite happening and that is the United Kingdom Association of Cardio-Thoracic Anaesthetists who are conducting a national audit of all the results of cardio-thoracic surgery both in adults and in children and it is all being co-ordinated through one single unit in Bristol. There was a lot of disagreement as to whether or not the information could be used in league tables and thereby distinguish between one hospital and another and we have found it very easy to prevent that simply by making the results of the overall system only available to the units themselves so only each individual unit gets the results of their unit and can see it in relation to the national results but no other unit can see that. That has been a mechanism to decrease the suspicion on the part of the trusts so it is feasible to do it.

911. Nevertheless we are grateful to you for bringing that potential threat to our attention. It has been suggested to us that the internal market is now imposing severe constraints upon extra-contractual tertiary referrals with consequential adverse effects on clinical research. Is this something on which you wish to comment?

(*Professor Sir Leslie Turnberg*) I think this is a widespread fear and it certainly seems to be the case. There are lots of examples now of patients with unusual diseases not being referred to the specialty centres because of the likely additional costs in so doing. It seems the SIFTR element has not protected the referral system. The charges per case undoubtedly have to be a bit higher even taking into account the relief a specialist centre has from SIFTR and this means that those departments which depend on undertaking research on patients with unusual diseases are limited. There are a number of examples of that already happening so we are concerned about that. We believe that it is important that there is a way in which those sorts of patients can continue to be referred, not only because of the research that they may support but because of the standard of care they

21 February 1995]

PROFESSOR SIR LESLIE TURNBERG, SIR CHRISTOPHER PAINE,
PROFESSOR CEDRIC PRYS-ROBERTS AND DR WILLIAM MCN STYLES

[Continued]

[Chairman contd.]

are likely to receive. That inevitably will mean some sort of funding adjustment to take account of it.

(*Sir Christopher Paine*) It really links these last two questions together with a problem; that there is a difficulty with multi-centre trials. It is more difficult in some circumstances, than it used to be a few years ago, to get these going. In cancer we have to depend on these particularly because of the real difficulties this makes for contracting, when some treatments may be more expensive than you would normally expect in a contract and some less so. So there is a problem with constraints for research in large multi-centre clinical trials which we need to find some way to address - I suppose by fully funding the research aspects of this in whatever way it becomes decided to do that, but there is a problem at the moment. We cannot get some cancer trials started.

912. It has, however, been suggested to us that even if you were to use the R component of SIFTR to protect certain tertiary referrals, or extra-contractual referrals—bringing down the price of those referrals in the specialist centre—that managers in peripheral hospitals would, nevertheless, refuse in some circumstances, to allow those cases to be referred; not so much on grounds of cost but on the grounds that they believe the patients can be properly treated in their own hospital. Is that something that you have come across?

(*Sir Christopher Paine*) I think this is where we continue to need more evidence day by day and it has to come through properly constructed research.

Lord Nathan

913. With regard to the constraints on sharing information which was discussed earlier, do those constraints arise largely from the lay managers or from the medical practitioners themselves? Likewise, so far as these particular problems you are speaking of have regard to tertiary referrals, do they stem from the administrators or from the practitioners?

(*Professor Sir Leslie Turnberg*) It is largely led on economic grounds, financial grounds. I do not believe that medical staff, by and large, are unwilling to refer patients. They are only too anxious. All the tension has occurred between the medical staff who wish to refer are being inhibited from so doing by an economic interest.

Lord Butterfield

914. It always seems to me that the importance of those tertiary referrals is that they are referrals to centres who are improving the quality of a treatment, and we will be cutting those centres down by not providing them with patients who need their help. That will be a very severe handicap for a well-founded, well-informed, knowledge-based NHS. Is that your view too?

(*Dr Styles*) I would very much support that view. I think as much as our concern about quality research, we are concerned, at the end of the day, about quality of services to patients. I would be concerned that this is being sacrificed with some of the problems we are discussing now.

Lord Gregson

915. Is there some way of improving the economics of tertiary referrals, do you think? To make it an incentive rather than a disincentive?

(*Professor Sir Leslie Turnberg*) The way the extra costs of the services required for those patients is funded will depend entirely on something like a SIFT element. That will have to come from some sort of top-slicing—something which, I suspect, is not very attractive in a system which operates through market forces.

916. That does not happen now, does it?

(*Professor Sir Leslie Turnberg*) If we can get to a system where there is cost per case—that is, the accurate costing of individual care for individual patients—then it may be that will help. At the moment, we have costs of groups of patients and contracts which are much larger and it is very difficult to tease out costs.

917. The tertiary referrals do not come within the contracts, do they?

(*Professor Sir Leslie Turnberg*) No.

918. It is another system?

(*Professor Sir Leslie Turnberg*) Yes.

Chairman

919. So if you have further thoughts on how this issue might be handled we would welcome further comments in writing.

Lord Butterfield] Is it not possible that the Committee might be able to get a little bit of competition between the different regions in their annual reports, showing how much money they spent on tertiary referrals? I am greatly in favour of managers and have always spoken up for them until they begin to impede what I regard, in my view, as important forward thinking for the NHS. I believe that the only way to equilibrate tertiary referrals is by getting someone to look, as the audit organisations do, at different expenditures on tertiary referrals in the different regions in future.

Lord Gregson

920. Maybe we should give an annual prize or something for the best tertiary referral!

(*Professor Sir Leslie Turnberg*) One of the difficulties arising is the collection of data nationally and bringing it to national attention. That is a gap that does need to be filled.

Chairman

921. Do you see any case for funding from the R component of SIFTR for a limited number of research beds or research outpatient clinics, with the excess service costs paid either from NHS or non-NHS sources?

(*Professor Sir Leslie Turnberg*) Briefly, my Lord Chairman, yes. I think this would be of considerable advantage. It would not have to be a very large number. But for a very small investment in specific areas one might get a considerable return and it is certainly worthwhile. One of the unfortunate effects over the last few years of restriction on funding has

21 February 1995]

PROFESSOR SIR LESLIE TURNBERG, SIR CHRISTOPHER PAINE,
PROFESSOR CEDRIC PRYS-ROBERTS AND DR WILLIAM MCN STYLES

[Continued]

[Chairman *contd.*]

been the loss of research beds and research facilities for clinical work.

922. We know that discussions are continuing about the possibility of an Academy of Medicine in this country. Can you say something about this?

(*Professor Sir Leslie Turnberg*) We would like to see something along those lines developing. The question you have put suggests an academy along the

lines of the Institute in the USA. There are several models for a possible academy, although I am not sure the Institute of Medicine would necessarily be the one best suited to the United Kingdom but, nevertheless, the Colleges are keen to see evolution in that direction.

Chairman] Thank you and again our gratitude for coming along to talk to us.

Letter from Sir Leslie Turnberg

Following our meeting with the sub-committee on 21 February, I am writing to thank their Lordships for giving us the opportunity to give evidence to them.

There are two matters I would like to take up. The first is in response to one of the questions on your list which we did not respond to at the meeting. We were asked about our assessment of the value of the Cochrane Centre and the York Centre for Reviews and Dissemination. Our views of the Cochrane collaboration are that this is a very important initiative and promises to be of considerable benefit to the Health Service. We are strongly supportive of its efforts in gathering and analysing information from the literature on effective treatments.

The York Centre for Reviews and Dissemination is, as yet, relatively untried and, while it may also be valuable, it is yet to prove itself. We would support the type of work being undertaken there and were impressed, for example, by its review of the management of glue ears. It is not absolutely clear whether there is a need for two such centres but it has to be said that there is much work to do in this field.

On another matter, we were questioned about our views on Locally Organised Research Schemes and we may not have made our position absolutely clear. There is no doubt that where these Schemes worked well in the past they were of enormous benefit in providing the infrastructure for research as well as funding specific project grants. A number of these, for example, that were in the previous North Western region, have disappeared and have been taken up within the R&D Directorate. I believe that this is potentially damaging and would strongly urge that a LORS function is maintained within the R&D structure, perhaps as a sub-committee, for the assessment and award of grants to support good ideas coming to it from the NHS.

I hope these further comments are helpful to the Committee in its deliberations.

23 February 1995

21st February 1995]

[Continued

Examination of Witnesses

DR C J ROBINSON, Chairman, National Association of Health Authorities and Trusts, Chairman, Northumberland FHSA, PROFESSOR J B L HOWELL, Chairman, Southampton and South West Hampshire Health Commission, MR S THORNTON, Chief Executive, Cambridgeshire and Huntingdon Health Commission, DAME MARGARET TURNER-WARWICK, Chairman, Royal Devon and Exeter Healthcare NHS Trust, MR M ELSE, Chief Executive, Royal Free Hampstead NHS Trust, DR A G MORGAN, Medical Director, Nottingham City NHS Trust, and MR D J MOSS, Chief Executive, Southampton University Hospitals NHS Trust, were called in and examined.

Chairman

923. Good morning, Dame Margaret, and gentlemen. Thank you so much for coming.

(Dr Robinson) My Lord Chairman, NAHAT is the leading organisation of NHS management bodies within the United Kingdom. It covers NHS authorities, health boards and NHS trusts, and it also has close links with GP fundholders. We have in our membership virtually all the commissioning organisations throughout the United Kingdom and the great majority of hospitals and community trusts. That is one of NAHAT's real strengths: the ability of both purchasers and providers to provide a comprehensive balanced view. The Association is represented by three purchaser and four trust witnesses. On my far left, Professor Jack Howell, who is Chairman of Southampton and South West Hampshire Health Commission; on my immediate left, Mr Stephen Thornton, Chief Executive of Cambridgeshire and Huntingdon Health Commission; on my immediate right, Dame Margaret Turner-Warwick, previous President of the Royal College of Physicians and present Chairman of the Royal Devon and Exeter Health Care Trust. Next to her, Mr David Moss, who is Chief Executive of Southampton University Hospitals NHS Trust and next to him, Mr Martin Else, who is Chief Executive of the Royal Free Hampstead NHS Trust, with a strong financial background; and on my far right, Dr Tony Morgan the Medical Director of Nottingham City NHS Trust. Could I say, my Lord Chairman, the Association particularly welcomes the greater interest and priority being given to both research and development throughout the NHS and also the greater priority being given to NHS needs by the wider R&D community. This is leading to improvements both in the care and treatment of patients and in the way that services are delivered. We welcome the Culyer Report and are in broad agreement with its recommendations about how NHS R&D needs to fit into both the wider R&D scene and the key changes that are taking place within the health sector: namely, the separation of the purchaser and provider functions and the creation of an internal market; secondly, the clinical and pharmaceutical advances, with their associated changes in patterns of care and treatment; and finally, the shift towards a primary care-led NHS. Inevitably, as we know, the Culyer Task Force only had time to look at principles. There is considerable uncertainty amongst ourselves and others as to exactly how those principles will be implemented in practice. We are particularly concerned to ensure that the relevance of basic laboratory research to clinical disease is not overlooked. Both the research

and developmental aspects of R&D are crucial to successfully carrying out the core functions of the NHS - those are improving the nation's health and providing care and treatment for those who are ill. We need to recognise the interaction between R&D, undergraduate teaching and postgraduate education and patient care, including the fact that resource, priority and major operational decisions in any of these areas are likely in the new purchaser/provider environment, to impact on the others even if we do not always yet fully understand how. We believe that R&D, teaching and postgraduate education need broadly to reflect how the NHS core services are being delivered and the continuing changes which are taking place. What we need to do in developing R&D post-Culyer, is to ensure that the balance between the core and other activities is right, and that practical solutions are found to the problems which can, and do, emerge as a result of change—for example: ensuring, where appropriate, that time is available to participate in multi-centre trials and, equally important, ensuring that satisfactory and simple indemnity arrangements can be made for non-negligent incidents. We generally agree to the Culyer recommendations for bringing together R&D funding although we would be concerned if this adversely affected continuing charitable and local funding. We support the updating of the central and regional R&D directorate structures, and committees to prioritise and commission R&D activities. Because of their interdependence, the two levels will need close working links. At the same time, both levels will need to operate with the degree of independence from other NHS activities which is traditionally associated with R&D activities. However, we would be concerned if these arrangements led to an over centralised approach to R&D, or if the central prioritising and clearing mechanisms resulted in an unbalanced programme of either clinical/applied or NHS-centred research. We strongly agree with the Culyer Task Force that greater emphasis needs to be put on R&D in the primary care sector. We would be concerned too if—as some observers have suggested—the Culyer recommendations led to a much higher proportion of bio-medical and clinical research being undertaken in a very few centres, determined by academic clinicians to the disbenefit of the remainder of the NHS. We support the Culyer proposal for a levy approach to financing R&D, since this underlines the relationship of R&D to patient care services, and the fact that there is only one pot of resources. It is essential that purchasers have a real and effective involvement in decisions about the size of the levy, and its broad distribution between the R&D

21st February 1995]

DR C J ROBINSON, PROFESSOR J B L HOWELL,
MR S THORNTON, DAME MARGARET TURNER-WARWICK,
MR M ELSE, DR A G MORGAN
AND MR D J MOSS

[Continued]

[Chairman *contd.*]

elements and, within those, the main areas to be covered. The levy arrangements should be organised so as to minimise collection costs. Having met their levy, we believe it is unrealistic to expect purchasers—whether health authorities or fund holders—to then also finance curiosity-driven research, except of course to the extent that an inquiring questioning approach is an essential element of the good clinical practice being purchased when buying all hospital and community health services.

924. Do you believe your members are going to see any benefits from the NHS R&D strategy and more cost effective health care?

(*Professor Howell*) Yes, indeed we are beginning to see benefits from the R&D strategy but, of course, what is being included at the present time is based on research that preceded the R&D strategy. The example which comes to mind is thrombolytic therapy and a great deal was known about that before the R&D strategy (the use of steroids in the mothers of premature infants is another example) but it is quite clear that the structure that now exists is going to produce an increasing amount of evidence for future clinical practice. What is important and I think it is widely recognised, and you have recognised it in your questions, is the importance of the dissemination of this information. It is self-evident that this is absolutely crucial but there are problems which I think have not been recognised. Only yesterday the director of public health in our health commission showed me the pile of papers that had come in within the last seven days amounting to several hundred pages of information which he has to digest. That did not include the York reports and what we might get from the Cochrane Collaboration or from regional reports such as the *Bandolier* of Oxford and Anglia region. In other words there is a huge amount of information about evidence of effectiveness, guidelines, protocols, from many sources, including special interest groups and all of these have to be digested, assimilated and filtered by them. This is a major task. We actually employ a librarian part-time to help with this task. I think the scale of the sifting of all of this information has not been appreciated. I believe it needs a management structure centrally or regionally to cope with it.

925. Thank you for that, that is a very helpful piece of information.

(*Mr Thornton*) My Lord Chairman, in the time that we have had available we have not been able to carry out an extensive survey of health authorities across the country but we feel certainly anecdotally that there has been a considerable amount of progress made in the area of evidence-based purchasing. What we are talking about here is a pretty fundamental change in the approach that is adopted by the organisations that purchase health care in this country, if you like, a culture change to focus very much more on their decisions being based on sound evidence. Clearly the whole Culyer research and development initiative is part of that. I would agree with the previous comment that it is very early days to be able to point to specific examples of where

the research and development programme has been followed right through to the point of changes in purchasing practice but there are certainly a number of examples of how purchasing practice is certainly beginning to change as a result of the general focus on an evidence-based approach. If I could just give you two examples from within my own authority of live issues that we have debated in this way in the last few months. One was in connection with homeopathic treatment and a very thorough piece of work that we did there when we looked at what we considered to be the effectiveness of secondary referrals for homeopathy. In exactly the same public meeting we took a paper that looked at infertility treatment, having brought two health authorities together, one in Huntington and one in Cambridge, where the practice was very different and for purely historical reasons one part of the patch had provided and another had not. This was not based on any sound evidence at all so we looked at it in that particular way. I think it is fair to say though that the dissemination of this material and the ability of my colleagues at health authority level to be able to assimilate it and understand it, to have the required critical appraisal skills to be able to make sense of this is really very crucial. I think there is a very important training and development aspect of this that all health authorities are going to have to endorse if we are going to move forward in this way.

926. In the United States, for example, the multi-centre trial of a procedure called extra-cranial/intra-cranial bypass for the management of cerebrovascular disease demonstrated that it was ineffective in preventing a stroke and as a consequence the purchasers were no longer willing to fund that particular procedure. Does what you are saying mean that it is likely that similar decisions may ultimately be made in the National Health Service, i.e. that various procedures shown to be ineffective will be no longer be funded?

(*Dr Robinson*) I think that is true. In fact, we have a table, which we will be passing to you, of an example from the Northern and Yorkshire region where the pattern of purchasing is now influenced by such evidence. It is beginning to happen but we should say it is a transition, as my two previous colleagues have said, and it is difficult to decide what are the consequences of R&D and what is the consequence of the beginnings of the critical appraisal process which was, of course, already in existence.

927. Is there a danger this might have an adverse influence upon what has always been regarded as the hallowed principle of clinical freedom?

(*Dame Margaret Turner-Warwick*) I think there are two points here we are discussing; the cost effectiveness and its assessment, which of course is very important to purchasers. The debate going on just at the moment of the right place of keyhole surgery is a very good example of a clash between the speed of development of a new technique and its clinical effectiveness versus the obvious advantage of cost; the other point I would like to make is there needs to be much greater clarity in what you mean by

21st February 1995]

DR C J ROBINSON, PROFESSOR J B L HOWELL,
MR S THORNTON, DAME MARGARET TURNER-WARWICK,
MR M ELSE, DR A G MORGAN
AND MR D J MOSS

[Continued]

[Chairman *contd.*]

effectiveness. Do you mean pure effectiveness, changing the natural history, or not changing the natural history of disease but perhaps avoiding complications, or simply symptomatic? I think there needs to be much more understanding by everyone, not least purchasers, of what question they are really asking before making snap decisions on effectiveness particularly in relation to cost.

Lord Flowers

928. Dr Robinson, in your opening statement you expressed concern that the Culyer recommendations might lead to a much higher proportion of bio-medical and clinical research being undertaken in a very few centres to the disbenefit of the remainder of the NHS. If it is true that the best research tends to be done in research intensive institutions and if resources are finite, you have posed a paradox, have you not?

(*Dr Robinson*) We did, as you say, discuss it at some length before we came here because as you might imagine from such a broad church, we are not exactly of the same view although general principles obtain. One of them is, as we shall come and address one of your subsequent questions, that in fact the quality of clinical provision is to a degree determined by the presence of research or not and therefore it is crucial that for instance we do not have in the future medical schools which are purely teaching institutions. It is our belief that that is potentially disastrous. On the other hand we are also conscious of the fact anecdotally we have been given a number of comments that imply that there is an excessive concentration of funding in what has been described as the "golden triangle" to the disbenefit of other parts. One has to recognise, as you correctly say, the advantages of having a concentration of critical mass and quality versus the need to in fact be able to address other issues and more importantly, of course, the fact that the issues may be regional or national issues because there are different ways in which they will be handled.

Lord Perry of Walton

929. Can I ask you what you meant by "golden triangle"? I would have thought it was a polygon and a very large polygon!

(*Dr Robinson*) The anecdotal comments, I have said, are not mine; I merely referred to the Cambridge/Oxford/London triangle.

Lord Butterfield] You have not heard of Edinburgh!

Chairman] I think that is perhaps an issue we should leave for another time!

Lord Flowers

930. It does sound to me, my Lord Chairman, that it is really a case for more money since you have not removed the paradox.

(*Dr Robinson*) That may be one solution, my Lord.

Chairman

931. How do you see as an association the mechanism continuing which at present operates the locally operated clinical research schemes, often giving people their first taste of research? What mechanism are you going to propose to see that continue?

(*Dr Robinson*) With respect, my Lord, our understanding is that the R&D strategy will in fact, implement that because the regional directors of course, as well as implementing national imperatives have the flexibility. I have to declare an interest, I did not describe my own background; I happen to be a member of the Northern and Yorkshire RHA and I do know our research director does in fact use that scheme to support local research.

Lord Perry of Walton

932. Most of us in listening to the evidence so far have been impressed by the fact that the concentration of bio-medical research in a few centres, I do not mean just three, is threatened. It is that which is threatened by the dispersal of such limited funds as are available all over the country to institutes which have no background in bio-medical research at all, yet you are suggesting that the likelihood of Culyer is that it is going to concentrate on just the few centres that you mentioned, namely three?

(*Dr Robinson*) I think we may be in danger of over-emphasising what we see as merely a point to share with you. Our concern is, in fact, that the research base is broad enough and strong enough. That is why we support the principle of Culyer about good research being supported and poor research being questioned and, in fact, not supported in the way it was in the past. The difference here, what we are looking at, is the broader church of research provision, based largely, I have to say, on existing medical schools and their catchments. There was the concern that one of the consequences of Culyer would be to draw money away from those bases into more favoured ones. That is merely giving you anecdotal concerns which have been addressed to us.

Chairman

933. You have said you are in favour of a levy on all purchasers. How should the size of the levy be determined? Within what limits would you expect the levy (as a percentage of purchasers' allocations) to fall?

(*Mr Thornton*) I think it is very important, when thinking about a new development such as this—particularly if it is going to be dependent upon garnering existing resources—that this is the starting point; and that built into the Culyer proposals we do not have an automatic assumption that this is going to need new money and somehow that new money ends up being taken from NHS purchasers by means of an increased levy. We very much support the concept of the levy. It will be the right thing to do, to focus all the relevant resources, garnered from whatever source—be it SIFTR or non-SIFTR

21st February 1995]

DR C J ROBINSON, PROFESSOR J B L HOWELL,
MR S THORNTON, DAME MARGARET TURNER-WARWICK,
MR M ELSE, DR A G MORGAN
AND MR D J MOSS

[Continued]

[Chairman *contd.*]

resources—and to make that a responsibility of the regional research and development team as they are the people who would, in the new arrangements, purchase the research and development. But I think the first step in that is to take all the existing resources which are devoted to research and development and work out what that proportion is. That is the first step. Then only beyond that point, by a process of agreement with all the parties, can one make some kind of an evaluation as to whether there is a need to increase that further. I say this because of legitimate fears from NHS purchasers that there are enormous demands placed on the resources that we have, not just for this kind of a levy but, if you like, levies for a number of new activities which the NHS is imposing upon us, and it competes with our purchasing of health services and health promotion activities which we legitimately engage in.

934. You are making it clear then, are you not, that the identification and declaration of R&D related expenditure is not going to be easy. Your present assessment of how much money is actually covered by SIFTR, is that not known in most of the regions at the present time?

(*Dr Robinson*) That is a very difficult question to answer. In theory it is known, but in practice it is actually very difficult to determine within any given institution - particularly within the teaching hospital settings, remembering that teaching hospitals are engaged in service provisions in teaching, they are also engaged in R&D—to be actually clear about just what the various income streams are being used for within that institution. There is a long-standing tradition, as you know, my Lord Chairman, of the knock for knock arrangements, whereby the kind of grey area that exists has largely been ignored to date within the introduction of NHS internal markets; and the introduction of what is, if you like, going to become a market for R&D to some extent. There is a feeling among a number of us that the days of the knock for knock are over unfortunately, and we are going to have to be much more open, clear, transparent, about costs and benefits so that each party knows what he or she is buying and how much it is costing them. In these days of cost equals price, that seems to me an inevitable trend that we are set upon but, of course, we have to remember that in so doing there are some significant transaction costs associated with that development.

Lord Nathan

935. To take that further, what are these transaction costs? It sounds to me as if you are embarking upon enormous expenditure which will probably be futile. Could you give us an idea as to the sort of money you are talking about?

(*Mr Else*) That again is an extremely difficult thing to predict at this stage. All one can say is that there is almost certainly going to be some sort of top-slicing of the R sum, as is identified for the management of that process. This is almost inevitable. There are going to be research and development directors in individual trusts, committees, managing the process. The judgment, as always, is about whether, at the end

of the day, that produces better research, managed or more effective research, than an arrangement where there is not that sort of management input.

936. I take it from what you have said that you are not, at the moment, in a position really to answer the question but how much are we talking about, either as to the proportion or in absolute terms?

(*Mr Else*) I cannot give you a specific figure but I can tell you that a number of trusts have already established the position of an R&D director, and there were usually some form of committee arrangements in place even before the establishment and implementation of Culyer. So there is already an arrangement in place around that structure.

(*Dr Robinson*) My Lord, I think you were probably asking about transaction costs. The point is that we are unaware of that and, indeed, the concerns of the Association—and I think it has been echoed in previous comments to your Lordships' Committee—is that there is a concern about balancing the cost of acquiring such information as opposed to the ultimate benefit. There is a real concern as to whether this is valid. We are unaware that research has been carried out and we think it is appropriate to address that before devoting resources, which are very scarce, to such a process.

Lord Perry of Walton

937. The T element of SIFTR is 75 per cent at least. That is not going to be taken away into a single research stream, it is going to be left. How would you like to see this distribution of the T element being handled now that there are trusts in all the medical schools?

(*Dr Robinson*) There is a problem about the distribution of T and that reflects the changing pattern of medical education, of which Lord Walton's previous medical school is a good example, where the base of teaching is widened out now into the peripheral hospitals and into primary care, so it is more difficult to address that. Perhaps I could ask Professor Howell, as a previous Dean, to give his view on it.

(*Professor Howell*) I do not know about the present because I am no longer a provider and SIFTR goes to the providers and universities, but certainly in the Wessex region, when we started the medical school at Southampton, we agreed to give a proportion of our SIFTR to the group of hospitals who were going to undertake the teaching for us.

938. When you say "we"?

(*Professor Howell*) At that time the control of SIFT was very much in the hands of the University. It was not ours but really the regional health authorities' but it used to come to the teaching hospitals. We felt that the use we were making of the district hospitals required us to give some of the SIFT money to those hospitals.

939. Yes, but I wonder what will happen now?

(*Dr Robinson*) May I ask, David Moss, the Chief Executive of Southampton University Hospitals to speak?

21st February 1995]

DR C J ROBINSON, PROFESSOR J B L HOWELL,
MR S THORNTON, DAME MARGARET TURNER-WARWICK,
MR M ELSE, DR A G MORGAN
AND MR D J MOSS

[Continued]

Chairman

940. Before you do, let us be clear: when you gave that SIFT money, it included the R component because that was not then separately identified; so some of the R component now identified was going to the peripheral hospitals?

(*Professor Howell*) Yes, it was.

941. That is an important point, thank you.

(*Mr Moss*) The current position is that the regional health authorities have a contract with the teaching providers for SIFTR and one envisages that the new arrangements for that will change slightly with the emergence of consortia who are buying education. In essence, there is a direct contractual relationship between purchasers of education and providers of education. That is fairly clear at the present time.

Lord Perry of Walton

942. Is it not true that the trust is now becoming the purchaser of education from the university?

(*Dr Robinson*) With respect, my Lord, my colleagues might correct me but my understanding is that it is still the postgraduate dean who has the funds for some of the teaching, but the local teaching is, in fact, likely to be devolved to consortia.

(*Mr Moss*) What we provide is clinical placements and infrastructure for teaching. Therefore, the postgraduate dean is responsible for the NHS funding of postgraduate education and the regional health authority is responsible for undergraduate education.

943. But the regional health authorities will cease to exist.

(*Mr Moss*) Yes. In this case they are being replaced, in this instance, by an education consortium.

(*Dr Robinson*) And the RHA part in respect of undergraduate teaching will probably be part of those consortia.

(*Mr Thornton*) My Lord Chairman, I think it is important for us to remember what SIFTR was. SIFTR has always been a rather crude cost subsidy mechanism to provide cost subsidies to teaching hospitals. Since those days different elements of SIFTR have been identified. One is the R component that we have been talking about this morning. That is going to be handled in a different way under Culyer and it is going to mean that that resource can be focused and moved around in a way that previously could not be, simply because of the price support mechanisms. It can now be moved according to criteria laid out under Culyer. That is a very positive step forward but we need to bear in mind that if any money of that sort is moved around in this way, according to criteria and values established by the research and development community, that it is going to have potential positive and potential adverse effects on those of us who are in another market here, the market for health services. The same is going to apply to the T part of SIFT. It is going to become increasingly—and already is becoming—a sum of money which is focused on good quality undergraduate teaching and should, in a sense, go to those institutions where that is provided according to a set of criteria. But again, if any of that money

moves from where it currently sits to other places, then that is going to have a knock-on effect on the health service market. So what we find ourselves having done, over a period of time, is to take a rather crudely applied cost subsidy mechanism and turn it into something really rather different. I think that leaves a number of us, whose job it is to purchase health care services, feeling: on the one hand, that this is very beneficial and very positive; but, on the other hand, we are very concerned about the potential for unintended consequences and the tendency for potential increases in cost which we might have to bear, particularly those of us who buy the majority of services from the teaching institutions.

944. When you say you have identified the R component, what do you mean by identifying it? It seems to me to be wholly a guess and nothing more than a guess.

(*Dr Robinson*) The dignified silence from my panel would give assent to that!

Chairman

945. SIFTR originally was intended to cover the increased staffing costs of a hospital and other relevant requirements to allow them to spend part of their time not just in the care of patients but also in teaching medical students. It was this Committee in 1988 which took the view that this should also cover the R component, in order to provide the infrastructure for research in these teaching institutions as well. We realise that you are going to have great difficulty in identifying what proportion of money should be put into the R component, but if you do succeed, it has been put to us that this R component should have two streams; one for the support of health services research and R&D in a traditional sense led from Professor Peckham at the centre but also, in many instances, provided by the regional directors of research and development; and a second component which should provide the infrastructure and facilities for biomedical curiosity-driven research in the hospitals. What is your view on dividing the R component, however defined, into two streams?

(*Mr Else*) It is absolutely essential from the main teaching hospitals' perspective that there is a recognition of the infrastructure costs which are required in order to support research. I have to say I think the same philosophy—to go back to an earlier question—is also being pursued in terms of SIFT, to teaching, and the same sorts of responses are going to come out when that particular exercise is completed. There is a core element of service that needs to be in place in order for both good teaching and good research to take place. We will all debate, I am sure endlessly, what that proportion actually is. You would expect us from the main teaching hospitals to argue that is quite a high percentage of the order of 80 per cent perhaps of R, but I believe there is evidence to support the fact that the infrastructure costs are very significant and that must be recognised within R and in SIFT.

(*Dame Margaret Turner-Warwick*) I think you have put your finger on a very important point because there is a conflict between the very necessary

21st February 1995]

DR C J ROBINSON, PROFESSOR J B L HOWELL,
MR S THORNTON, DAME MARGARET TURNER-WARWICK,
MR M ELSE, DR A G MORGAN
AND MR D J MOSS

[Continued]

[Chairman *contd.*]

health services research which has been neglected in the past right across medicine for paramedics as well as medics. It is a very important part of Mike Peckham's initiative, but if we do that at the expense of what I would say United Kingdom's pre-eminence in this special area of research which is the transfer and examination of basic laboratory research into its clinical bedside relevance, the pathogenesis of disease. The laboratory research may be very clever at identifying all sorts of wonderful bio-chemical proteins from a cell but they will then assume that that is relevant to clinical medicine and it might be quite irrelevant. The strength of British research and the NHS has been applying those basic ideas to clinical medicine and hence the implications for therapy. If we ignore that in our effort to improve health service research I think we shall have done great long-term damage, which is I think the point Lord Butterfield made earlier.

(*Dr Morgan*) Can I comment that the emphasis which the R&D strategy gives to health services research is fine but it must not do that at the expense of basic medical research. If you look at the recommendations of the group on cancer, for example, you will have to go a long way down the list before you find anything that you would say was basic medical scientific research.

946. Those are the recommendations of the CRDC group on cancer you are referring to?

(*Dr Morgan*) Indeed.

947. Of course there are innumerable examples of situations where today's discovery in basic medical science brings tomorrow's practical development in patient care—we can all quote those. It has been suggested that rather than allowing the regional directors of research and development virtually total control over the R component of Culyer, the trusts and medical schools and individuals involved in academic research should be involved locally in disbursing of these funds. Do you wish to make a comment on that?

(*Dr Robinson*) We support this. I will ask Dr Morgan to speak first.

(*Dr Morgan*) Only to endorse the suggestion. It is mutually beneficial to the teaching hospital trusts and to the medical schools with which they are associated to ensure that the funding is directed in appropriate ways and a number, as has already been said, have established research directors and committees designed for that very purpose.

(*Professor Howell*) In your description of the two streams you mentioned something which I was unaware of and that was curiosity driven research should be funded from the second stream together with the infrastructure costs.

948. Forgive me, the infrastructure for curiosity-driven research, as the dual support system in the universities requires that the well-found department with appropriate facilities should be there in which that research can be carried out.

(*Professor Howell*) My concern would be therefore that curiosity driven research would only have its infrastructure in certain institutions whereas there

are people throughout the NHS who might have a question they would like to test before knowing whether it was something to proceed with.

949. Wholly accepted. The question that we wondered about was where you said you wanted the levy "to finance curiosity-driven research, except of course to the extent that an inquiring questioning approach is an essential element of good clinical practice." That I think is an issue which is obviously of very considerable importance.

(*Mr Thornton*) Lord Chairman, I think all of us are very supportive of the broad thrust of the Culyer proposals but I think there is a particular paragraph in the Culyer report, paragraph 3.39, which talks about purchasers of health care allowing providers the freedom to continue to support pre-protocol work, curiosity-driven research and similar activities and to provide for the costs where these cannot be met by external sponsors. I believe the report goes on to say they consider this to be "marginal". I think that is a real concern for those of us who are health service purchasers. What do we mean here by "marginal"? Clearly any kind of good quality clinical practice needs to have embedded in it elements of critical assessment and curiosity driven exploration but where does that begin and where does that end and where does that become something that needs to be properly converted into a research and development proposal before other significant work can be done. I think we have a real fear here as the purchasers that there may become an expectation that if research and development proposals cannot be approved for expenditure within the levy then the next port of call for the R&D community is to come to local purchasers and expect funding here. I think once we have fulfilled our responsibilities by providing our share of the levy it is actually unreasonable to expect health purchasers to pick up the costs of any extensive curiosity driven research as defined by Culyer.

950. Do you think all purchasers in the NHS are at present equipped to make strategic judgements about research?

(*Mr Thornton*) My Lord Chairman, not at all.

951. That is another problem that has to be faced.

(*Dr Robinson*) My Lord Chairman, that is the issue you raised in one of your other written questions and perhaps we may address it then.

952. What do you feel about the proposal that research grant proposals involving the use of NHS facilities and requiring therefore service support should be signed off before being submitted?

(*Mr Else*) My Lord Chairman, I think we see that the signing off of the grant proposals is really in parallel to a system we already have for services and that is around business cases and developing financial assessments and all the economic aspects of a particular service or research based proposal. They have very many things in common. There is already an established process of business case assessment. It is something going on in all trusts at the moment. Therefore, other than the fact it would take place usually within the added complex environment of a

21st February 1995]

Dr C J ROBINSON, PROFESSOR J B L HOWELL,
Mr S THORNTON, DAME MARGARET TURNER-WARWICK,
Mr M ELSE, Dr A G MORGAN
AND Mr D J MOSS

[Continued]

[Chairman contd.]

teaching hospital (we have heard a little bit about the complexity of the income streams that come to the main teaching hospitals) but other than that added complexity generally speaking the process exists already in order for the trusts themselves to evaluate and sign off research proposals. It is important the trusts sign it off because at the end of the day they are committing the resources and they are the ones I would imagine being expected to be accountable for delivery of research outcomes. In undertaking that process of course it is very important the trusts maintain collaboration with local and other purchasers. Again the main university hospitals have multiple purchasers. They operate within this very complex environment and it may well be more than one purchaser, but clearly the host purchaser will have a significant input to that process. It is about the trusts taking very significant input into the process, signing it off formally and accepting responsibility but also in collaboration with purchasers.

953. What do you see as the future of the funding of academic posts in clinical medicine across the board by the NHS?

(Dr Robinson) Perhaps I could ask Mr Moss.

954. Yes.

(Mr Moss) We would have some concerns about this issue. As you are probably aware, there is a patchwork of arrangements around the country at the moment and the NHS does fund varying percentages of academic staff in teaching hospitals. We believe that there are clear advantages in this synergy and it needs very careful handling in the future. A blanket approach to this would be potentially destabilising for some centres.

(Dr Robinson) Mr Thornton, as a purchasing manager, has a particular interest in this as well.

(Mr Thornton) Yes, my Lord Chairman, one of my concerns is that with the abolition of the regional health authorities, we need to put in place appropriate mechanisms to pick this up. In many parts of the country it has been the regional health authorities who have provided the funding for such academic posts and it is somewhat unclear as to what the future arrangements will be. One suggestion is that the role of the regional health authorities should be taken over by consortia of purchasers. But in so doing it is very important that we are clear about the criteria that are established, either for continuing this funding or increasing it; or, in turn, shifting this funding in different kinds of ways. It is very, very important that we get across here the importance of the multiplier effect; that this kind of investment is made in institutions and in places where further resources can then be attracted as a result of the initial investment. It is also important to address some areas where the quality of clinical practice needs to be significantly improved. Certainly it is the case in Cambridge that this mechanism has been used very effectively to bring about increased investments in areas where there has been a need dramatically to improve clinical practice, and the whole input of an academic perspective and investment through the clinical school has dramatically raised standards over a period of years.

Lord Butterfield

955. The first thing I want to say is how pleased I am to see that you have three qualified doctors and they have all been involved in curiosity-driven enquiries. I would like to pay a tribute to Professor Jack Howell who went once a week, I understand, and inhaled dust as part of his asthma research, which resulted in very significant improvements in the therapy for asthmatic children. It seems to me terribly important and I just plead that there is symbiosis between those people who are concerned with research, including curiosity-driven research, and the quality of the service. I am anxious that that obtains between all of you. Let me just tell you a story which I do not want to go in the record [...]. It is going to be terribly important that when you purchasers top-slice money for research, to get a director of research interested in that—because, in a way, it is a bit like my case—taking money and making sure that their particular use of it got the first grip of it. So I do think that transparency—this wonderful new word—is going to be the important thing to make sure that the health service does not fragment into providers, some of whom will be doing wonderful (like Jack Howell) curiosity-driven research and you purchasers. The importance of that is, to me, immense. I do not know how you are going to do it. It is probably going to mean that whoever you appoint to be your research director has got to be a man who really knows the accounts, and can talk to the people who want to do research about the accounts in a way they recognise is well-informed and knowledgeable.

(Dr Robinson) May I clarify that because I think there are some important points. The first thing is that we see a mechanism whereby the purchasers will have very strong links with the local regional director of R&D because they will be very much influencing his disbursement, as Lord Walton pointed out, of the local fund. That is the first part. The second part is that within the trusts they have already established research and development directors. They have a team which is a balanced team and, indeed, in a number of the areas now the regions are, for instance, putting in health economists as part of an initiative to ensure that. In my own region this has happened. The teams, when they are functioning, have a balanced view and, if you like, their deliberations are very similar to the sort of collaborative balanced view which the Culyer Committee and the regional research committees will be doing. But it is important that it is not a single focus—even for primary care nursing which you referred to.

Lord Butterfield] May I go one step further? One of the things we have all got to realise is that when you appoint a director of research or health economist, or all kinds of people, there will be folk who are doing curiosity-driven research and who will feel that it is going to make it more difficult for them to get the cost of the dust that they want to inhale. That is why transparency and understanding of the problems on the two sides of the fence is so important in this field.

21st February 1995]

DR C J ROBINSON, PROFESSOR J B L HOWELL,
MR S THORNTON, DAME MARGARET TURNER-WARWICK,
MR M ELSE, DR A G MORGAN
AND MR D J MOSS

[Continued

Lord Perry of Walton

956. I think what Lord Butterfield has covered is very important but it leaves a gap in my view; it is the gap of pre-protocol curiosity-driven research within a trust. I was slightly shocked when you said, "It would be unrealistic to expect the trust in whatever hospital to fund any such curiosity-driven research." I think this is a recipe for a total lack of morale amongst the medical staff and some of the interested non-medical staff who have got ideas that they would like to push through. They cannot be expected to go and get money from the research groups, the standard research groups. I think this is a disastrous fragmentation.

(*Dr Robinson*) May I justify this? If you remember, the whole purpose of Culyer was to encourage that which is worth encouraging and discourage that which is worth discouraging. In other words, we are actually focusing resource. The important principle is that presumably the committees are going to identify those things which are worth doing. The difficulty must be faced that if there is an open cheque book—I think which Mr Thornton was referring to earlier—given to every provider unit, for everybody to pursue their own particular whim, then, to a degree, we are undermining Culyer, that is the problem.

Chairman

957. That particular possibility has always existed. Anybody in any hospital throughout this country who is curious about developing a new technique, or who is looking into a particular problem which they want to explore, has been able to go to the regional research committee in the past and get a grant to undertake that research. You never know where the new rising stars are going to arise. What we are concerned about is that those existing facilities for someone to engage in that kind of research are not going to be destroyed by direction in a top-down way. That, I think, is our concern.

(*Dr Robinson*) If I can say two things? The first is that, in fact, we have already accepted the infrastructure of the day. That is part and parcel of it. The second thing, as you have pointed out, is the fact that people can still go to the local regional director of research and development and get support. I think what Lord Perry was referring to was the stage before that and that is obviously of concern.

958. Yes, understood.

(*Professor Howell*) I think the key words here are "unrealistic to expect the purchasers ...", and I would defend that. I am a purchaser and I am aware of the pressures on us to provide health care for our community. We have already through the levy given something like £3 million/£3.5 million towards central R&D funding. If somebody with curiosity driven research requires any major expenditure such as bringing individuals into hospital when they would not otherwise have been admitted or serial MRI scans, that sort of expenditure, if that is required then I think they have to find separate funding for it from somewhere. If on the other hand they wish to do research on patients who are already

in hospital—for example, they want to do additional serum sodiums or other relatively inexpensive things, then I think that must be absorbed within the trusts. It would be unrealistic to go to a purchaser to ask for those sums of money. It would be impossible for the purchaser to fund major amounts of money; we do not have it.

Lord Perry of Walton

959. I could not agree more. It is the low level that I am bothered about. Once it gets to major expenditure of the sort you mentioned it does become a protocol; it has to. That is alright as the system is there for it but it is the small scale that I am bothered about.

(*Professor Howell*) I think that can go on. I have thrived on curiosity driven research all my life. The sums involved were always small. I did not admit patients separately for research. I believe the purchaser could provide for that in certain contracts¹.

960. I think you did not say that to begin with.

(*Dr Robinson*) My Lord Chairman, I think the question was about what purchasers would actually pay for. If I could ask Dame Turner-Warwick, who now chairs a non-teaching hospital trust and then David Moss to give very brief comments on it.

(*Dame Margaret Turner-Warwick*) I hope in part this can be tackled in a slightly pragmatic but useful way by education between the trust provider and its local purchaser. If the local purchaser appreciates that this is low cost, it is a very good idea, it is quality for the future, it is the starting seed corn and the spirit of appreciating the importance of curiosity driven research in those early stages, then together the trust provider and the purchaser should have that flexibility to do something about it. I understand Professor Howell's great constraints on his purchasing ability but I still believe there is room for flexibility and we must protect that at all costs.

(*Mr Moss*) I want to make the point that one of the reasons that my trust wanted a director of research and development is to nurture and encourage research, not to control and direct it. So we do take a view that we will grow our research organically not just by focusing it into specific channels.

961. What in fact you are saying is that it is going to be supported by the provider rather than directly by the purchaser?

(*Mr Moss*) Yes, but of course you have problems if a trust is in association with ten or more purchasers, not just over this but the signing off of research projects.

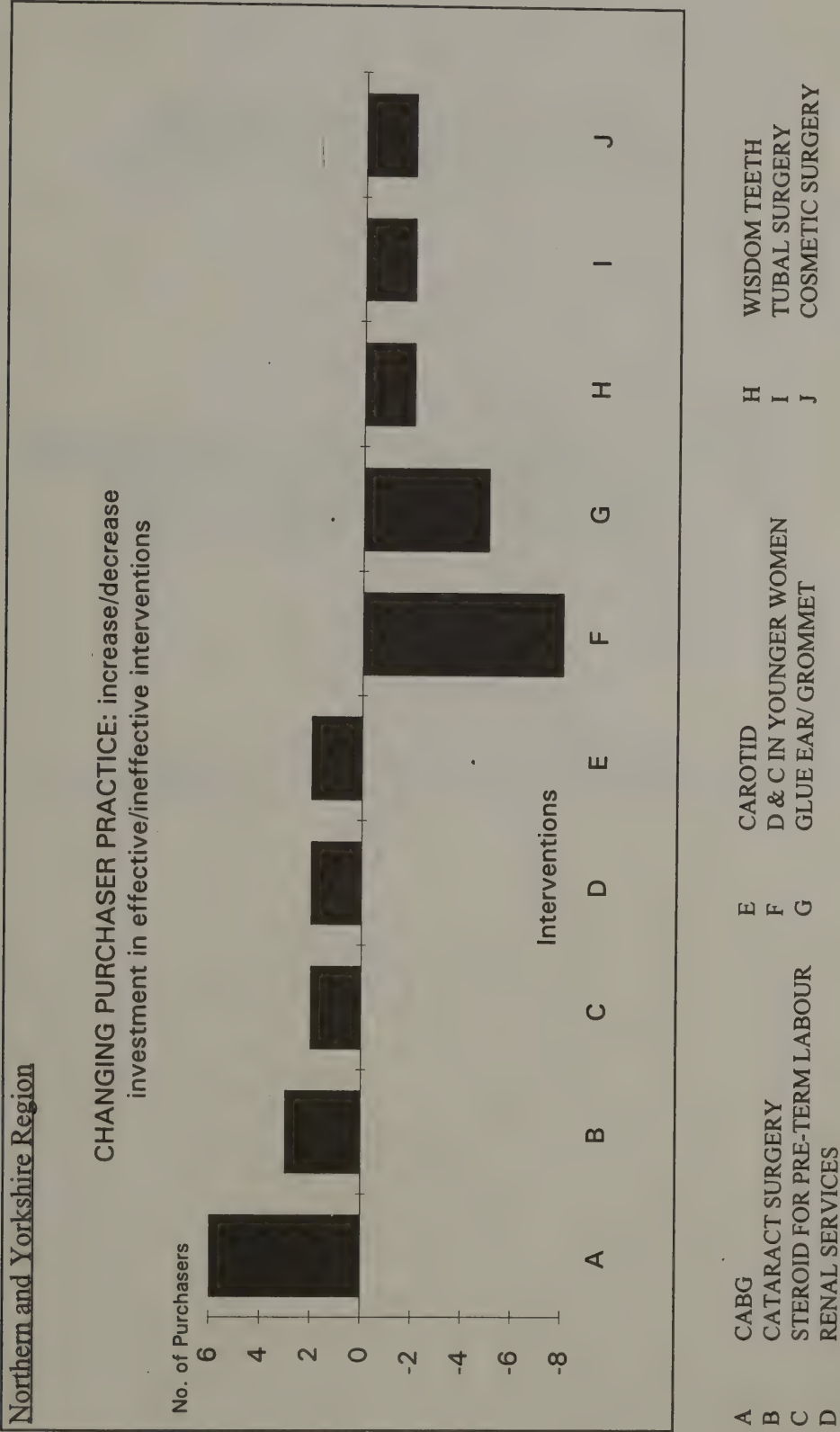
962. I can only yet again say our sincere thanks on behalf of the entire Committee for coming along and giving up your time.

(*Dr Robinson*) Thank you very much for hearing us; we are most grateful.

¹Note by the witness: This would be in the areas of treatment when some margin of uncertainty was recognised and consequently an allowance would be made for low cost curiosity-driven research.

21st February 1995]

[Continued



**SELECT COMMITTEE ON
SCIENCE AND TECHNOLOGY**

**MEDICAL RESEARCH AND
THE NHS REFORMS**

PREVIOUSLY UNPUBLISHED EVIDENCE

TUESDAY 28 FEBRUARY 1995

Present:

Butterfield, L.
Nathan, L.
Perry of Walton, L.

Walton of Detchant, L.
(Chairman)

Memorandum by the University of Aberdeen

1. The Culyer Report and indeed the NHS R & D Strategy do not formally apply to Scotland. It is clear, however, that the "R & D Strategy for the NHS in Scotland" will be influenced by developments South of the Border.

2. The evidence presented in this paper supports the general issues raised in evidence from the CVCP and Council of Deans.

3. The general aim of supporting high quality R & D to improve health and healthcare is welcomed. The recommendations of the Culyer Report—to separate funds for R & D and service support from funds for other activities, to ensure accountability, to place primary and community care sectors on an equal footing with the acute sector—are both relevant and acceptable. The proposal to fund these developments by a levy on purchasers is also appropriate, provided that GP Fundholders are included.

4. While the general principles are acceptable, there are concerns about their implementation in practice.

5. These arrangements inevitably depend upon equity and transparency of funding across the system. Within Scotland these prerequisites are not currently met. Revenue funding to Health Boards is based on the per capita allocation modified by standardised mortality rate data (based upon deaths under the age of 65 years). This may not be the most appropriate form of funding with current demographic changes; healthcare provision for the elderly may not be sufficiently resourced. Moreover such funding no longer includes resources for medical staff in training grades whose numbers like those of their consultant colleagues vary widely between different health board areas—and even more importantly between the four teaching Health Boards. The basis of calculation to inform the arrangements for distribution of ACT funding is no longer clear. Thus it will prove difficult to "separate funds for R & D and service support from funds for other activities" without producing serious imbalances in healthcare provision.

(a) Research and Development

(i) The development of an R & D Strategy supported by a single funding stream has advantages in terms of focus and accountability but may result in conventional, short-term approaches to complex problems. Directed research programmes have not been successful in the past. There will be a need to ensure that sufficient support is maintained and science-based projects are not overlooked in favour of practical service-led ventures. The emphasis on high quality, peer-reviewed research must be maintained.

(ii) Within the NHS itself there is not a robust research base. At a time when the importance of R & D is being increasingly appreciated, it is unfortunate that changes to the postgraduate training of doctors may further erode their research skills. The Culyer Report acknowledges the lack of research culture in the professions allied to medicine. For these reasons it is important that the role of academic medicine is both understood and developed in support of the agreed Strategy. The successful implementation of the R & D Strategy will inevitably depend upon the involvement of academic staff cooperating with NHS clinicians and managers. Once again clinical academic staff are well placed to help establish this vital collaboration.

(iii) The lack of a career structure for R & D researchers is acknowledged. The universities and their medical schools are able to assist by providing the infrastructure and the necessary balance of established and short-term research posts. For many years this approach has been adopted in Scotland with the Chief Scientist Office linking its research units to a university. This policy is relatively easy to implement in Scotland.

(b) Resources

(i) The creation of a single funding stream for R & D will assist with accountability and focus but will prove difficult to implement. The 25 per cent SIFTR (ACT) accepted as the proportion devoted to supporting research, is an arbitrary figure. Moreover the concept that such funding might be withdrawn from the teaching hospitals and re-allocated in support of the R & D Strategy is superficially attractive but impracticable in the short to medium term. These funds have, however inappropriately, been used to support the hospital infrastructure for many years. Their rapid withdrawal would undoubtedly lead to difficulties in

*28 February 1995]**[Continued]*

service delivery. The additional funding (£40 million) recently allocated to SIFTR but not ACT will assist this process.

(ii) The proportion of academic staff funded by the NHS through SIFTR (ACT) varies widely in different medical schools (from 12-60 per cent). This type of university/NHS cooperation has allowed a number of specialties to develop—to the undoubted benefit of the NHS. The effect of any re-allocation of funding on such desirable developments would have to be carefully considered.

(iii) There is, however, a more fundamental difficulty. Academic staff funded by SIFTR (ACT) contribute substantially to the research output of the university and thus to its rating in the Research Assessment Exercise organised by the Funding Councils. If R & D is to be assessed by the same mechanism, it is important that the first recommendation of the Culyer Report is fully implemented ie that R & D funds are separated from funds for other activities. The effect of re-allocating the R component must be linked with objective and transparent overall funding for all service activity in the local area including medical staffing costs.

(iv) The R component is not intended to fund research directly but to provide the infrastructural support for such activity. It will, therefore, not be possible to re-allocate 25 per cent of SIFTR (ACT) in support of the R & D strategy without a substantial reduction in the ability to deliver the proposed research. The Culyer Report does not identify the proportion of SIFTR (ACT) that might be reallocated—presumably substantially less than 25 per cent. It will, however, be important to agree this proportion without delay. The current uncertainty makes it more difficult to allocate existing SIFTR (ACT) funds in support of desirable long-term projects.

(v) The Cochrane Centre is a valuable initiative which in the long-term should provide an important information base for the R & D Strategy. The York Centre is likely to be of considerably less benefit. Health Technology Assessment is important but perhaps more limited in scope than is desirable: all new and many established procedures should be appraised as necessary.

(vi) In conclusion the principles of the NHS R & D Strategy and the Culyer Report are supported. If their objectives are to be realised implementation must be sensitive to overall funding of the system and the academic community must be fully involved in order to ensure high quality research to expand the evidence-based approach to healthcare.

Memorandum by the University of Glasgow

1. Subcommittee 1 focuses on the NHS R & D Strategy and on the Culyer Report, but neither applies formally to Scotland. It is fairly certain, however, that the principles underpinning the strategy and the issues developed in the Report will come to have an important bearing on research in the NHS in Scotland.

2. From a University perspective, there is, and should be, quite a marked distinction between a research strategy determined by a Medical School and a research strategy which is determined—and “commissioned”—by the NHS. In Scotland, the distinction has been somewhat blurred by the successful operation of the Chief Scientist Office which has disbursed research funding on the basis of high quality peer review. Even if there is now a refocusing of research to cater for NHS priorities—including “Health Services Research”—we anticipate that the Chief Scientist Office will continue to exercise the same control over quality of research and funding as it has done up until now. The success of this operation has undoubtedly been the result of close collaboration between the Chief Scientist Office and academic institutions in Scotland.

3. Although the single explicit funding stream for research recommended by Culyer is attractive, there is unease about the destabilising effect of interfering with the ACT allocation and distribution system in Scotland. Attempts have been made to identify the (implicit) R component of ACT and the recent Price-Waterhouse report commissioned by the four Teaching Health Boards (Lothian, Grampian, Tayside and Greater Glasgow) has provided a basis on which further studies of the true service and infrastructure costs of teaching and research can be based. The concept that a component of the ACT allocation can be specifically earmarked for research, held back and then allocated on the basis of a research assessment seems sound. It would be regrettable, however, if two Research Assessments (HEFC and NHS) emerged.

4. We have been encouraged to develop an academic research strategy as part of our accountability to the Scottish Higher Education Funding Council. This strategy is flexible enough to embrace priorities set by the Scottish Office through the Chief Scientist Office. The primary stimulus for the strategy, however, arises from the academic institution and this should continue to be the case. At the point of Research Assessment, however, we hope that the value of incorporating NHS research priorities into our overall strategy will be recognised.

5. We welcome the Culyer proposals to direct funds to research in primary care and the community. This is entirely in keeping with shifts in service provision from the acute sector to the community and will be reflected by an increased emphasis on undergraduate teaching in the community. From first year of the medical course, students should gain vocational experience and training in primary and community care settings and a research environment will only serve to enhance their experience.

*28 February 1995]**[Continued*

6. NHS Trusts (in Glasgow) are starting to consider R & D issues in response to SOHHD initiatives. While there is a potential for conflict between the Trusts and the University vis-à-vis staff effort, time and resources, this will be minimised by ensuring the closest co-operation between both parties. Effective liaison systems and joint membership of research committees will ensure harmonisation of research aspirations and objectives.

Letter from D J H Brock, Professor of Human Genetics, University of Edinburgh

Thank you for your letter of 8 February, inviting my views on medical research and the NHS reforms. Rather than repeat what I told the House of Commons Science and Technology Committee's enquiry into human genetics when they visited Edinburgh in January, I shall address the questions that you pose.

1. If I understand the NHS R&D strategy correctly, Regional Research Committees decide on research priorities and then invite bids for mission-directed projects. This seems to me a disastrous policy. Those who have time to sit on committees of this nature will inevitably be distanced from the cutting edge of research and therefore prone to ask the wrong questions. This is borne out by my own experience. I have a considerable reputation in the field of heterozygote screening for cystic fibrosis. The NHS R&D's programme in this area, put out last November, was so appallingly and ignorantly misdirected that I could not respond to it. None the less, there is a vast amount of important research which is urgently needed in this important area.

2. The Culyer Report makes the same mistake as Peckham, in believing that research is best controlled and directed by national fora or regional committees. In my view all the evidence points in the opposite direction. There is, of course, considerable virtue in a levy, but this will be dissipated if the funds are poorly used. The UK has one of the best records of any country in medical research and has gained this by using scientists to propose projects and their peer groups to judge the suitability of the proposals. I cannot understand why we are now contemplating moving to a committee-led system.

17 February 1995

Memorandum by the Council of the Royal Society of Edinburgh

1. The Royal Society of Edinburgh welcomes the single stream funding mechanism for research activities outlined in the Culyer Report which refers only to England and Wales. The Society wishes both to highlight some of the distinguishing features of the Scottish Health Service and, as Scotland's premier learned Society, to express its concern that any changes in the funding mechanisms or allocation procedures do not diminish the role and importance of curiosity-driven research within the Health Service.

Scottish Structure

2. The organisation of the Health Service in Scotland differs from that in England and Wales. Scotland does not have individual regions, but does have a Chief Scientist. There are no individual Directors of Research in the Health Board areas (the equivalent of the English regions), nor are any planned.

3. The equivalent to SIFT(R) in England and Wales is the Additional Cost for Teaching and Research—ACT(R). In England and Wales 25 per cent of SIFT(R) is research. The Society would therefore anticipate that in Scotland 25 per cent of ACT(R) allocation would also be for research. In the Scottish situation it seems to the Society to be logical that the research component of ACT be identified and administered at as local a level as possible, requiring tripartite collaboration between the Medical School Dean, the CE of the relevant Trust or Direct Managed Unit and the Treasurer of the Health Board.

4. In the Chief Scientist's Office (CSO), Scotland already possesses a forum for regular liaison between representatives of all aspects of Health Service management, namely the Chief Scientist, the Chief Medical Officer and the NHS Management Executive. The Chief Scientist's Office and the Management Executive issued a joint document in 1993 developing a research and development policy for Scotland. The CSO is an appropriate route for the distribution to teaching hospitals of the research component of ACT(R), which should then be implemented locally.

5. An additional source of funding for medical research in Scotland is the Scottish Hospital Endowments Research Trust (SHERT). There is excellent communication between SHERT and the CSO.

6. The Society understands that a national forum is being gathered together in England and Wales to supervise centrally NHS R&D. Scottish interests should be represented by the Chief Scientist or his or her deputies.

*28 February 1995]**[Continued]**Research in the National Health Service*

7. The Society welcomes the clear identification of that component of central funding to be used for research. However, research in the NHS should not be restricted to Health Services research. The Society wishes to emphasise the need for research that could be seen to fall outside that definition of R&D on page 14 of the Culyer Report, which seems to preclude non-goal directed research: eg, biomedical and genetic research. Scottish hospitals and medical schools have a long tradition of high quality research in these fields. R&D in the Health Service includes original work with implications in the long term as well as that with immediate operational applications.

8. The Society wishes to express concern over three related outcomes of the Health Service reforms which it believes will have a detrimental effect on the quality of research in the Health Service.

(i) There is evidence that senior clinical academics have less time to devote to the research component of their responsibilities because they have to spend increasing time on Committees and other management bodies.

(ii) The new NHS training grades and the implementation of the Calman proposals have resulted in a reduction in the numbers of junior clinical posts, eg, in one Scottish university they have been cut to 16 from 46. This will reduce the time available for high-quality research traditionally carried out in this training grade and it also raises concern for the future as we look to this group for the future academic leaders of their disciplines.

(iii) There is some evidence (see article by Professor Smyth in the British Medical Journal, August 1994, 309, 457-61) that the newly formed Trusts and to a certain extent fund-holding general practitioners may affect some aspects of clinical research, notably clinical trials.

9. Britain attracts good research workers from all over the world because of the high quality of the research carried out here. In part, the quality has been due to the superstructure provided by the NHS (eg access to populations and records) which is not available in many other countries. This facility must not be put in jeopardy.

10. The Society agrees with the Culyer recommendations that all research in the NHS should be subject to scientific quality control by the peer review process, but cautions against an expansion of bureaucracy.

11. The Society welcomes the concept of a register of research projects in the NHS. This should cover all projects: those funded by Research Councils and charities as well as by ACT(R) money. Annual progress reports would be useful, and the register should be accessible to any interested parties.

Funding mechanisms and allocation of funds

12. As mentioned in 4 above, the Society believes that the distribution of the research component of ACT(R) funding should take place as locally as possible, ie, at medical school and Trust level, to minimise bureaucratic procedures.

13. The Society welcomes the proposal in the Culyer Report that costs are broken down into facilities, service and project funding and the proposal that there is a review of the terms on which the NHS provides service support to external funding bodies.

14. At present the Scottish Universities are already considering their submissions to the Research Assessment exercise which will take place in Spring of 1996. This takes up a considerable amount of clinical academic time and it is strongly recommended that the results of this assessment exercise should be used as the basis for the allocation of research funds within the NHS.

15. The concept of top-slicing health purchasers' allocations for R&D requires further elaboration.

16. Some mechanism must be found for "money to follow the patient". Extracontractual referrals are essential if the excellent biomedical studies and clinical trials carried out in the past in Scotland are to be continued.

Primary care and community health research

17. The Society welcomes the emphasis on developing quality research in the primary care and community health sectors. However, the Society believes that this should not be at the expense of hospital-based research. Additional funding should be made available for research in the community.

18. Research in primary care and in the community should also be subject to quality control with adequate peer review.

28 February 1995]

[Continued

Conclusions

19. The Royal Society of Edinburgh welcomes proposals for the co-ordination of all health service related research and for the streamlining of funding procedures, but wishes to reiterate the point that not all research carried out in the NHS is health services research, i.e. geared toward operational problems and delivery of care. These are certainly important areas worthy of research, but the Sub-Committee is urged to consider the vital importance of other sorts of research that are not goal-directed, but curiosity-driven. In the Society's view, the funding and excellence of this research should not be jeopardised.

6 February 1995

Memorandum by the Scottish Hospital Endowments Research Trust

I enclose written comments on the Culyer Report agreed by members of the Scottish Hospital Endowments Research Trust at their meeting on 3 February. I apologize for the late delivery of the comments but we had to wait for the quarterly meeting of the Trust in order to air our views and prepare a consensus opinion.

Our principal concern is the effect that the Reforms might have on support of modestly costing opportunistic or feasibility studies. The Trust give top priority to this kind of research which is, of course, the seed-bed of all major advances in the sciences and is, alas, much too neglected by the bureaucracy emanating from thinking big!

Sir Alwyn Williams, Chairman

10 February 1995

The Scottish Hospital Endowments Research Trust is an independent body, constituted under the Hospital Endowments (Scotland) Act 1953 (and the subsequent National Health Service (Scotland) Act 1978), to receive and hold endowments, donations and bequests and to make grants from these funds to promote medical research in Scotland. Additionally, it is empowered by the National Health Service & Community Care Act 1990 to engage in fund-raising activities for the purposes of the Trust and is required by the Health & Medicine Act 1988 to develop and exploit ideas and to exploit intellectual property.

In responding to the Call for Evidence for the enquiry into medical research and the NHS reforms, the members of the Scottish Hospital Endowments Research Trust have confined themselves to addressing the proposals contained in the Culyer report (Supporting Research and Development in the NHS).

1. In general terms, the Trust believes that the Report's attempt to reconcile the two cultures which currently prevail in the biomedical research community, namely basic medical/scientific research and Health Services research, is to be welcomed.

2. The trust is of the view, however, that the proposals in the report raise genuine concerns and these are summarised as follows:

2.1. A new CRDC will have the power to control NHS R&D spending and service support for externally-funded research throughout the NHS and research proposals will have to be considered by two different organisations:

- (a) the appropriate NHS body (CRDC-required committee or Trust)
- (b) a research fund (Medical Research Council, charity etc)

It is believed that this may lead to excessive delays in securing funding for important projects.

2.2. Centralisation of funding will tend to favour the "top-down" direction of research and may neglect to recognise that much important and worthy research is generated in the science and clinical laboratory, and the pay-off is often long term. The emphasis is likely to be on operational research in the NHS and, important although this is, basic medical/science research may be marginalised.

2.3. It is envisaged that small local, or "pump-priming" projects should be funded without access to central or regional R&D funds. It is these very projects which may be denied support by finally stretched providers, who are likely to pass the decision up the chain in an effort to obtain finance from R&D funds.

2.4. There is concern that local and national endowment funds may be assimilated into the NHS R&D plans. The Trust believes that these should be considered, along with other charities, as external sources of funding.

2.5. While agreeing that SIFT(R) funds (ACT(R) in Scotland) are vitally important, the Trust believes that the suggested mechanism for their distribution is unnecessarily bureaucratic. The Trust would look for a more direct method of redeployment of these monies in the new system.

28 February 1995]

[Continued]

Examination of witnesses

PROFESSOR GRAEME R D CATTO, Dean of the Faculty of Clinical Medicine, University of Aberdeen, PROFESSOR PETER HOWIE, Department of Obstetrics and Gynaecology, University of Dundee, PROFESSOR C R W EDWARDS, Dean of the Faculty of Medicine, University of Edinburgh, PROFESSOR BRIAN WHITING, Dean of the Faculty of Medicine, University of Glasgow, representing the Committee of Scottish Higher Education Principals, were called in and examined in the rooms of the Royal Society of Edinburgh.

Chairman

963. Good morning, gentlemen, and thank you very much for being willing to come and talk to us. What is your impression of the initiatives towards an NHS R&D strategy for Scotland taken by the Chief Scientist Office since 1993 and what has been their impact on your medical schools?

(*Professor Edwards*) My Lord Chairman, thank you. I am certainly impressed by the strategy with its emphasis, in fact, on cardio-vascular, mental health and community research but I am not impressed as yet with its implementation. It seems clear at the moment that there is a lack of integration between the Chief Scientist's Office and the Management Executive with regard to trying to put this strategy into place. As a result, as yet this strategy has yet to make any impact on our medical schools. The only sign we have had of activity is the recent setting up of the NHS trust hospital R&D committees.

964. Would any of your colleagues wish to add anything to that?

(*Professor Catto*) I think that certainly applies to the Aberdeen situation as well.

Lord Butterfield

965. Do you envisage then that you will perhaps be directing researchers to get interested in this or that or the other from the CSO's priorities list?

(*Professor Edwards*) That is an extremely important question. It makes perhaps tactical and strategic sense that we should be locally communicating those priorities to research workers so that they recognised they stood a greater chance of success in those areas. I think we would all like to emphasise that we do not recognise, and we will come to this, directed research and we do not wish to pursue what is fatally flawed research simply because it is in a strategic area.

Chairman

966. The Scottish Office Home and Health Department is giving increased priority to health services research and we would like to enquire as to whether the clinical bio-medical research, sometimes called "curiosity-driven research", conducted in your medical schools is suffering as a consequence. Our Clerk has produced for us a very useful summary of three documents, from which it would appear that the CSO research grants budget for 1993 to 1994 for health services and public health research, has gone up from £3.3 million in 1992 to 1993 to £4.86 million in 1993 to 1994, whereas the budget for acute health care research has gone down from £3.7 million in 1992 to 1993 to £3.04 million in 1993 to 1994. In addition to this about another £1.7 million has been devoted to what one might call "operational

research" into disability, equipment valuation and health assessment technology and we would welcome your comments on these figures.

(*Professor Edwards*) We are obviously very dependent in Scotland, I think, on funding from this source and if there is a change in that funding it clearly is going to have an impact on clinical research. I know that we all feel that we are advantaged in Scotland by having a Chief Scientist and we feel this individual very much has in mind the support of clinical research and I think that that is a very important point that we should make to you. Obviously we are concerned if there is a reduction of funds for general clinical research but what I think the Chief Scientist has been trying to do is to focus on his priority areas and I think that we would find that was a reasonable policy. We would, however, be concerned if what was happening was what is defined as acute health care was really to go down progressively and that was going to be replaced by health services research because we all recognise that this type of research, even though it is important, is not the entirety of clinical research.

Lord Butterfield

967. Looking at that figure, which we have been given, 3.7 down to 3.0 for acute health care research, does that mean people with acute health care research projects have been side-lined and funds directed toward health services and public health research? Is that your feeling? Are there people queuing up wanting to do research who cannot get funds?

(*Professor Catto*) Yes, I think that is the situation. The movement so far has been relatively small in financial terms. Therefore I suspect for any individual medical school the impact has yet to be felt. It is the sense of direction that is the cause for concern.

Lord Perry of Walton] It is, of course true, is it not, that from the MRC and charities you got £50 million and we are talking about £3 million. It is a very small part of the total.

Chairman

968. In proportion to total population Scotland seems to have done very well with the Medical Research Council with £30 million in 1992 to 1993. You do not appear to have done quite so well from the cancer charities and other charities. Is that your own perception? Is that group of figures a selective and unrepresentative figure or does it reflect the normal pattern of funding for research in Scotland?

(*Professor Edwards*) I think on the whole that Scotland does extremely well, certainly from the charity point of view, and if one looks at the Wellcome Trust figures, which are well known to me,

28 February 1995]

PROFESSOR GRAEME R D CATTO, PROFESSOR PETER HOWIE,
PROFESSOR C R W EDWARDS AND PROFESSOR BRIAN WHITING

[Continued]

[Chairman *contd.*]

then Scotland has two of the Universities in the top ten funded by the Wellcome Trust. My own feeling from that perspective is that Scotland is doing well. I cannot comment on your figures without further analysis.

Lord Perry of Walton

969. There are four medical schools out of 22 so it is not ten per cent of the population; it is 20 per cent nearly of medical schools. I was wanting to ask Aberdeen, have you got any examples of your statement that directed research programmes have not been successful in the past?

(*Professor Catto*) My Lord, I suspect the two that are best known were the cancer initiative in North America in the 1970s and the MRC funding for HIV in the last decade. In both of these situations there was a suspicion that research not of high quality was being funded. I think the distinction we would wish to make is between directed research and attempting to prioritise research; on the one hand with peer review we are supportive, on the other we are slightly concerned.

970. Do you think that the Scottish Home and Health Department is, in fact, moving too far in that direction?

(*Professor Catto*) Not as yet, my Lord.

Chairman

971. This reminds me very much of Sir Douglas Black's very interesting comment in his Rock Carling lecture commenting on the Nixon initiative to try and throw money at curing cancer where he said, "Lavish finance is impotent in the face of unripe time." It was a characteristic Blackism. What would you say about the Culyer Report? Would you like to see it in whole or in part implemented in Scotland?

(*Professor Edwards*) That is obviously an extremely important question, my Lord. Can I make some points for and some points against. I think that we are supportive of the separation of specific funds to support clinical research and of the breaking down of the costs so as to have specific infrastructure costs and to recognise the facility costs. I think we would all like to feel there was an external peer review process and that we should have this as part of a research assessment exercise and not have a separate process. I think it would be helpful to have a register of research in the NHS. As far as funding goes, top slicing should in fact be an appropriate way of proceeding but when one comes to the community aspects of the Culyer report, even though we would all support the increased emphasis on this, we would not wish this to be at the expense of research in teaching hospitals. Our particular concerns are that there should not be a new bureaucratic layer in order to get back this money. There should not be a slavish commitment to health services research at the expense of basic clinical research. I am particularly concerned that the definition of clinical research which is used by Culyer. I think if you look at that carefully, is not a definition of clinical research that any clinician would normally accept.

972. In what sense would you wish to see that definition changed?

(*Professor Edwards*) I do not believe it is possible, for example, to say that all research should be supported on the basis it is generalisable. That is one of the points in his definition, for example. There are many aspects of medical research which when it first started was curiosity-driven research and in no circumstances when it started could you have said that the results could be generalisable. Because people have pursued that it has resulted in something which was eventually generalisable but it could not be identified *de novo*.

973. You are opposed to any suggestion of short-termism and I have often quoted that today's development in basic science brings tomorrow's practical development in patient care.

(*Professor Edwards*) Very much so.

974. We have, of course, been told by all witnesses that it would be wasteful of time and energy to mount a separate research assessment in the NHS and some way must be found of combining the examination of research in the NHS with that being undertaken in universities under the research assessment exercise. It has also been suggested to us that if one is able to identify and separate off the R component in SIFTR in England and ACT in Scotland, that in turn might be divided into three separate streams. One stream might be used for central distribution, for prioritised research through either the Director of R&D in England and his regional directors or through your Chief Scientist Office in Scotland; a second component might be used at a much more local level to support health services research which is not directed centrally but planned locally and might include a certain component of research in general practice or involving the other health care professions and might also include the locally operated clinical research scheme as is operated in England; but a third and major component of this funding might be devoted to providing the infrastructure and the facilities needed in the hospitals for clinical and curiosity-driven research. Does that principle commend itself to you?

(*Professor Edwards*) I think in general, yes. There is a real need to identify the infrastructure and I think you are right in saying this would be by far the largest part of this funding, but I think that we are all concerned as to what is being defined as the infrastructure because it is going to be extremely important that we understand the range of costs involved in clinical research. For example, we all appreciate there needs to be an increased number of staff in the medical records department, laboratories and other parts of the hospital. Providing those costs were incorporated in the infrastructure I think we would be reasonably happy. I am concerned, and I know others are, that a separate exercise is going on in relation to recognising the infrastructure for teaching. I think a particular concern is how you could possibly disentangle the teaching infrastructure from research. In many instances it is part of the same infrastructure. If they are going to have separate review processes for research and teaching I think we are going to find particular

28 February 1995]

PROFESSOR GRAEME R D CATTO, PROFESSOR PETER HOWIE,
PROFESSOR C R W EDWARDS AND PROFESSOR BRIAN WHITING

[Continued]

[Chairman contd.]

problems. That is an area which I think needs special emphasis.

975. I think we would share your concern about that.

(*Professor Whiting*) Can I say I am also extremely relieved that you said that the major portion of that funding would be for infrastructure. I think what we fear is if the central funding for the Peckham initiative for NHS research is taken away, that might limit academic freedom in carrying out research. It would tend to favour directed research which we are somewhat opposed to.

976. How dependent are your medical schools and their teaching hospitals upon the research element of ACT? Do you regard the notional figures of 25 per cent used in Culyer as being a reasonable estimate of that R component?

(*Professor Whiting*) Certainly, my Lord Chairman, the Price Waterhouse study in Scotland identified costs as being about 25 per cent and we would regard the 25 per cent as absolutely crucial to medical schools and teaching hospitals which perform research.

Lord Butterfield

977. Do you mean essential, or crucial?

(*Professor Whiting*) Essential.

978. In other words, my Lord Chairman, you are suggesting that 25 per cent is the bottom figure, are you?

(*Professor Whiting*) Yes, the bottom figure.

(*Professor Edwards*) To support that one should make the point that in the Price Waterhouse review they found that out of a total of £121 million that £30.7 million was required for research, ie a quarter, that of course was a mean figure across the whole of Scotland. I think if one is looking at the more active areas in terms of research, one could argue that those institutions might require a higher percentage than 25 per cent.

Chairman

979. The Peckham initiative has set out to try to achieve 1.5 per cent of total NHS funding in England devoted to this kind of activity. Do you regard that as being an adequate figure? Has a similar percentage figure been set in Scotland?

(*Professor Edwards*) No, it has not. I think that your Lordships are well aware of the fact that Scotland has not had a similar structure and, as such, the same sort of budget has not been set but, of course, against that is the fact that we have had a Chief Scientist organisation in place for many years and we view that organisation as being equivalent to the Peckham initiative and we do not have, of course, the regional directors of research which that structure has. There is a structure in Scotland but it is different. I think it is clear that the budget for the Chief Scientist would need to reflect what was being put in place down South. We would like to have a structure certainly in budgetary terms equivalent to that.

980. There is now a proposal, is there not, that every health board in Scotland should be asked to appoint someone, perhaps on a part-time basis, with responsibility for R&D?

(*Professor Edwards*) Yes.

981. Do you think that is likely to be implemented?

(*Professor Edwards*) It appears to be being implemented at a local level and certainly I know that the trusts are setting up their own R&D structures. I think it is highly likely to be the case.

Lord Butterfield] Will charges be made to your research budget for the administration of those structures? When we met recently some people concerned with purchasing I, and I think the other Members sitting with me, were a little alarmed to hear one man say they were quite in favour of a research budget as they would top-slice what they needed for administrators and the rest would be for the chaps in the lab. That almost sounded to me upside down. So I am wondering whether perhaps your budget is so comfortable in Scotland that you can afford chaps to keep an eye on things!

Lord Perry of Walton

982. Could I revert to the 25/75 per cent. I think, Professor Edwards, you told me once that the 75 per cent is distributed by the dean and trust acting together?

(*Professor Edwards*) Yes.

983. We also, I think, discussed several times getting evidence at the Committee about how the teaching element has got to be carried out if this is going to be carried out in a research-based atmosphere. Therefore a lot of the T element is being distributed to support basic research in the teaching departments. So in fact the 25/75 is not a very real figure in that sense.

(*Professor Edwards*) We all recognise that it is a purely pragmatic split. I clearly understand the problems that people have had. An enormous amount of time and money has been spent on trying to disaggregate these costs without success. The major success has clearly been in the pockets of the management consultants. In terms of clarity I think we do not have that. What I would feel is there has to be some basis to start and so 25 per cent on the figures we have available to us in Scotland seems to us to be not unreasonable.

Chairman

984. Do you anticipate any serious difficulties over the proposal, if Culyer were implemented, that the funds required to support research should be top-sliced from the budget already providing patient services?

(*Professor Catto*) I think in Scotland, or certainly parts of Scotland, one of the difficulties would be the GP fundholding element. Provided there were plans to include the GP fundholders as well as the health boards I think that problem might be ameliorated, it could be got round.

985. Have you any idea what proportion of GPs in Scotland are fund holders at present?

28 February 1995]

PROFESSOR GRAEME R D CATTO, PROFESSOR PETER HOWIE,
PROFESSOR C R W EDWARDS AND PROFESSOR BRIAN WHITING

[Continued]

[Chairman *contd.*]

(*Professor Catto*) In Grampian more than fifty per cent of the population are now covered by GP fund holders. It varies very widely, I think we have the largest proportion.

986. In Lothian or Strathclyde?

(*Professor Catto*) Significantly lower.

Lord Nathan

987. I was wondering what thoughts you had with regard to research into "community care" (rather than primary care, because it seems to be a totality) and how you saw that developing? I did note that you said whatever happens any money for that purpose should not be deducted from other funds.

(*Professor Edwards*) I think we would all support the fact that this is an extremely important issue. I would make two points. First of all the separation of specific ACT funds for general practice, which resulted from a Committee chaired by Professor Howie, who is the professor of General Practice in Edinburgh, has had a very beneficial effect on academic general practice and research in general practice. We all have to recognise there is not a large cohort of people with the ability to carry out this research. I think we should give support to academic general practice and this has been a major step forward. Secondly, we need to recognise that as part of the Chief Scientist's strategy, that support for community research is one of his four top priorities so I would hope additional resources would be coming through that means. It is terribly important to realise you cannot start research *de novo* in the community without having the right people to carry out that research. I think the emphasis that has been placed on the funding of academic research in general practice will start to produce the calibre of people who will be doing that. Of course, those people will also be linking up with the departments of public health science within universities who again have a particular interest in research in the community.

988. Has there been a trend in Scotland as in other parts of the United Kingdom, towards community paediatric services and community psychiatrists?

(*Professor Edwards*) Yes, there has.

(*Professor Howie*) Can I make the point that a great deal of health services research examines the interface between the hospital and the community. Many of the projects you see reflected in the increased funding that was described earlier from the figures given by the CSO in fact reflect a great deal of research that is done which is in the community and is of value to the community and that may be one strong direction in which community based research can be supported.

989. The Royal College of General Practitioners has funded a certain number of research practices by giving additional funding to allow research-type facilities to be available in those practices and in one or two instances research sessions have been paid for from external sources for GPs. Is this a development that you would commend?

(*Professor Edwards*) Very much so. I think it complements this additional cost of teaching

funding. Currently in Lothian about £200,000 a year is going in a ring fenced way into general practice to support academic general practice and research and this is a way obviously of supplementing that.

990. How would you envisage support being provided for research in the other professions allied to medicine, nursing, physiotherapy, occupational therapy, dietetics and many more?

(*Professor Catto*) My Lord Chairman, I hope the approach will be a team-based approach there. The danger we have is splitting and fragmentation when I think the approach ought to be the opposite, bringing together under groups and teams and attacking it in that way.

(*Professor Howie*) Can I make the point about the support of research for nursing. As you may know, there is the process of trying to place colleges of nursing and midwifery in the higher education sector. Bids are currently being sought by the management executive in Scotland. I believe those institutions who bid to become providers should ensure as part of their bids that a research component to improve the quality of nursing research be part of these bids. True integration of nursing within the higher education sector requires they embrace the research environment for teaching which is applied to the higher education sector in general. I think that is one route nursing research should be supported.

991. To date the academic departments of nursing which have existed for some years have had relatively poor ratings in the research assessment exercise. Of course, many of them are young and relatively new to the field of research. Do you have any ideas about how the development of research in these fields might be stimulated?

(*Professor Whiting*) There is an important initiative in Scotland and that is the setting up of a Nursing Research Initiative for Scotland. I think that will be a tremendous challenge for the future. May I make one point about ACTR for general practice? There is a large problem with it and that is the degree of uncertainty about its future and the fact that it is released in yearly instalments. My Professor of General Practice says this makes planning for long-term investment and long-term research almost impossible. What we are really saying is we think research in general practice is absolutely crucial but the long-term planning is extremely difficult at the moment.

992. Professor Catto said that the approach to community care has got to be on an integrated basis. Have you any thought with regard to how this should be structured or, indeed, how it is structured?

(*Professor Catto*) There has been an initiative in the past year in Scotland looking at how community hospitals could best be employed using general practice and primary care teams in that situation. I think it goes along with what Professor Howie was saying about how research, which was once considered to be hospital-based, can now move out into the community and reach through these community hospitals with professionals working together down into general practice levels. That may be one way forward.

28 February 1995]

PROFESSOR GRAEME R D CATTO, PROFESSOR PETER HOWIE,
PROFESSOR C R W EDWARDS AND PROFESSOR BRIAN WHITING

[Continued]

[Lord Nathan *contd.*]

993. Do you envisage other disciplines in universities being involved in this exercise?

(Professor Catto) Yes, without doubt.

Lord Perry of Walton

994. I am still in doubt about the statement that was made, I think by Professor Edwards again, that the number of lectureships in Edinburgh had either fallen or was going to fall from 46 to 16 because of the new situation. Can you tell me what proportion of the 30 that are going were paid for by the university?

(Professor Edwards) If I could clarify exactly what I said last time which related to the south east of Scotland. We will hear from my colleagues that the position round Scotland is clearly quite different. The Scottish Office were proposing a reduction in the number of registrars from 241 in 1993 to 132 in 1996. Going along with that we were having to reduce the number of lecturers from 46 down to 16. Now those 16 that remain are ones which are actually going to be funded by the NHS. It so happens that is the number we have that are funded. It was thought it was most appropriate we should do that on the basis that the individuals in those posts would not be capable of being differentiated from other people who were NHS-funded directly because they will be carrying out very few academic duties and their role with regard to teaching and research would clearly be reduced.

995. The 30 that are not remaining are all university paid? (Professor Edwards) They are mainly SHEFC funded, yes.

996. What proportion of that 30 are lecturers, senior lecturers and professors?

(Professor Edwards) These are simply lecturers we are talking about.

997. They would hold honorary contracts as registrars or senior registrars?

(Professor Edwards) Obviously with the unified training grade that distinction will disappear but they will be part of the unified training grade, yes.

998. In the new scheme you cannot have those honorary registrars?

(Professor Edwards) No.

Chairman

999. And the 30 lecturers who will continue to be funded by the university, will they not have honorary registrar status with the NHS?

(Professor Edwards) This is where a lot of the problems arise. What the university is planning to do is to make some of these posts into two to three year research lecturer posts, some into five year fixed term senior lecturer posts and very few would be converted into chairs. So we are having to adapt. What I think is of particular concern about the new structure is its rigidity. If one looks at a simple example—someone who is on the unified training grade and wishes, for example, to apply for an MRC or Wellcome Clinical Training Fellowship. As this scheme is currently described, if that person were

awarded it and they moved out for two or three years in order to do that fellowship, it would produce a major problem for the university with regard to how that vacancy would be filled because we would not be able to get someone who came in who would get any recognition for the time they had spent in that post. The only way to fill that vacancy would be by bringing in an overseas registrar.

1000. A visiting registrar?

(Professor Edwards) Yes.

1001. There is no ceiling on visiting registrars at the moment?

(Professor Edwards) No.

1002. Can you give us any idea in Scotland as to what proportion of registrars in the NHS or honorary-registrars in the university are in post as compared with the number of visiting registrars?

(Professor Edwards) There are very few visiting registrars in Lothian.

Lord Perry of Walton

1003. What proportion of the 30 jobs have already been lost? Are they all still in post?

(Professor Edwards) What we are doing is obviously recognising this is not something you can do overnight and so as each post becomes vacant so we are having to plan as to what we should do with that particular post. We have already made, in four or five instances, specific changes in relationship to individual posts.

1004. The money has not been nobbled by the other faculties. You still have it?

(Professor Edwards) We still have it.

1005. What is the total number of senior lecturers and professors paid by the university?

(Professor Edwards) When we look at the clinical academic staff, people who work in hospitals, in Edinburgh we currently have 22 per cent that are paid by the NHS. The rest are coming from other sources, not necessarily the funding council.

1006. What is the number paid by the university as compared to the 30 lecturers?

(Professor Edwards) I will need to take advice on that.

1007. Could you let us know?

(Professor Edwards) Surely.

Chairman] It would be helpful to us if each of you from your respective universities could give us some evidence as to what your current establishment is of academic posts in clinical medicine across the board in the three grades, professors, senior lecturers and lecturers, and some indication of the number that were lost as a result of the Higher Education Funding Council's reduction in financing over the last ten years, the number that were frozen or disestablished and also some indication of what proportion are now being funded by the NHS.

Lord Perry of Walton] We have the figure for Edinburgh. It is 30 funded by the university and 16 by the NHS. So it is the number rather than proportion.

28 February 1995]

PROFESSOR GRAEME R D CATTO, PROFESSOR PETER HOWIE,
PROFESSOR C R W EDWARDS AND PROFESSOR BRIAN WHITING

[Continued

Chairman

1008. That is only the registrars. That does not include the professors and senior lecturers.

(*Professor Catto*) I think the suggestion we look at this over time is extremely helpful. There will be very great disparity in different parts of Scotland. Some of us, for example Grampian, have already got down to the levels anticipated by the unified training grade but of course that has happened over a period of time. If we can look back over ten years and give you those figures and compare them with the current arrangement that would be extremely helpful from our point of view.

1009. That we would like to have because we would wish to have an indication first of the cuts in clinical academic posts funded by university funds over the course of the last ten years. We also would like to have some indication as to how those cuts have been compensated for by NHS-funding of academic posts in clinical medicine; also the extent to which posts have been funded in clinical academic medicine on a ten year basis, if they have been, by charities and other external sources.

(*Professor Howie*) Would it be possible to have these questions in writing so it is absolutely clear what you are looking for and we can collect this data in a uniform manner?

1010. I am sure we can.

(*Professor Whiting*) 22 per cent of senior clinical academic staff in Glasgow are paid by the NHS. Those are FTE figures. It might be quite difficult to produce the figures you want because of partial funding, partial recoups, but you would like a complete breakdown?

1011. It would be extremely helpful to us because of our concerns about the future of academic medicine in general terms. It would inevitably involve asking how many A plus B appointments you have in Scotland i.e. those part-funded by the university and part-funded by the NHS. I know that varies enormously in different universities.

(*Professor Howie*) The number supported in Tayside by the NHS is extremely small and much smaller than in other areas although with the development of the trusts that trend is being reversed and they are seeking to use their ACT money in this way.

1012. Is that one of the future hopes for preserving the identity of clinical academic medicine, persuading trusts that in areas which are in need of clinical and research development that they should fund more academic projects?

(*Professor Howie*) We have been encouraging that trend.

(*Professor Whiting*) So have we.

Chairman] Perhaps I can float with you one very tentative suggestion, which has only been discussed very informally between Lord Perry and some of us. He has suggested the possibility that if an individual goes into a registrar/lecturer post he will be given in future a number under the Culyer proposals. If that person steps aside for three years to do a PhD to develop his or her research expertise, they will take that number with them. The only way the vacancy can be filled on a locum basis would be by a visiting registrar. Effectively this would mean that an

individual would spend three years longer in training than the average NHS person going up the ladder. If there was some way of designating some individuals as being on the academic ladder, is that one way of protecting their future in academic medicine?

Lord Perry of Walton

1013. If they were given a number that had an A designating an academic post and they could then only hold honorary contracts in the NHS, they could not hold full-time contracts, it would block their transfer into full-time clinical service medicine. It would remove the objection that they were supernumerary posts in the training grade and would therefore destroy the balance that had been achieved by the numbering system.

(*Professor Whiting*) My Lord, at the Council of Deans the other day we were talking about the potential loss of seedcorn for senior lecturer posts. What it would do would ensure that seedcorn was somehow maintained and nurtured.

1014. That is what I am trying to get at.

(*Professor Whiting*) It has the flavour though of almost promising senior posts to people with that prefix A.

1015. The senior posts would have to be funded by the universities which is why one needs to know what the numbers game is if one is going to make this work at all. It does, of course, restrict the freedom of the individual; he is committed to an academic career.

(*Professor Whiting*) Absolutely.

1016. It is possible, I suppose, if an academic post is filled by somebody who has a non-academic number, in other words comes under the clinical scale, then one vacancy would be available for a non-academic number to move into a purely service job.

(*Professor Edwards*) We have been extremely careful about limiting the interface between the NHS and academic side because that has been a very fruitful interface. It would be worrying if we made it into an impenetrable barrier. I think there are ways in which universities might respond. Obviously you would need to be careful to get honorary consultant status. I could, for example, see there might be an extension of the schemes like those that happen at the moment for the bio-medical scientist, the non-clinical scientist, such as the Wellcome University Award Scheme, where someone is recognised as having the potential for long-term employment by the university but they are going to have a focused period of research for three years and then gradually be taken over by the university in the next two years after that. The person can have a very specific role in basic research in relation to medicine initially but know their long-term career was going to be assured. I think for a few people such awards might be entirely appropriate.

Chairman

1017. You would never envisage, would you, and I am now speaking to you as a Wellcome trustee, a situation where that body sitting on a hugely increasing pot of gold, at least potentially, might allocate to the individual medical schools and

28 February 1995]

PROFESSOR GRAEME R D CATTO, PROFESSOR PETER HOWIE,
PROFESSOR C R W EDWARDS AND PROFESSOR BRIAN WHITING

[Continued]

[Chairman contd.]

universities throughout the country funds which could be used exactly for that purpose?

(*Professor Edwards*) I think, in keeping with all bodies that fund research, the Trust recognises that our major focus is on people; it is not on institutions, and simply because a persuasive dean or principal goes to the Wellcome Trust and asks them for N million pounds to put up a building that is not enough. There has to be a programme of research and a person associated with it. I cannot see any organisation, even one in the fortunate position that the Wellcome trust is in at the moment, writing blank cheques for universities.

1018. You mean not so much Wellcome senior research fellowships, which are solely for research but Wellcome senior lectureships, if that particular programme is to be continued?

(*Professor Edwards*) It has been a spectacularly successful programme. We all very much hope it will be continued. I think the answer is that we are in changing times. I am sure the Trust would welcome a dialogue with the universities on this.

1019. Thank you.

(*Professor Catto*) I think it would be extremely useful if we had that long-term commitment to the individual, rather than have a divide between clinical and academic. I would regret very much if we came back to the era of the clinically inept academic and we would be at risk, I think, of that happening if we had the type of divide we discussed earlier.

Lord Butterfield

1020. One of the problems that has arisen about it being a purchaser/provider setup is that some of the purchasers are not very interested in purchasing expert care from research units for rare diseases. That is understandable because as purchasers they may not understand the potential planning of long-term research projects. There is some difficulty in sustaining patient flows required for research south of the border. We wondered whether you were having any of the same kind of problems and, if you are, have you got any ways of solving them?

(*Professor Edwards*) My Lord, we are having the same sort of problems. I think we all have to recognise that there is a need for having a referral practice of difficult and complex clinical problems. Indeed my own research over the last ten years has been based on a single case of a 21 year old with hypertension and hypokalaemia who was referred from Wessex. He turned out to be a unique example; the first adult case of a symptom previously only described in a few children. It has led to fundamental advances in terms of our understanding of how the kidney works. I feel we have to facilitate that process. In a meeting we had recently with the Wellcome Trust where people were asked to present their research to Virginia Bottomley and David Hunt, one of the research workers from Cambridge drew Virginia's attention to a major problem he was having. He is interested in insulin resistance and he had found when studying leprechaunism that it was impossible to get any of those patients into a bed in Cambridge to be investigated. I think there are clear examples where these very rare cases are the

substrate for basic clinical research which may be generalisable in the long-term. My own recommendation is what should happen is that limited funds should be made available to enable extra contractual referrals of patients for clinical research.

Chairman

1021. We have been notified ourselves of two specific examples. One of the hospitals in London has done major trials, centre-based originally, on the treatment of Guillain-Barré Syndrome, where having had an average referral from regional hospitals of 20 patients a year, last year the number fell to three. Another example was of a specialist soft tissue oncology unit where because of the particular expertise in cancer they used to get pathological samples referred from all over the country. There had been a major reduction in the number because the referring hospitals would not pay for them. It has also been put to us that another problem on the horizon is that even if you identify funds to bring down the cost of such tertiary referrals in the specialised centre to what would be the comparable cost in a regional non-teaching hospital, you might find managers then saying, "Why refer this patient, because we can give perfectly good treatment for this particular condition." How do you overcome that kind of attitudinal problem rather than a financial one?

(*Professor Edwards*) I think the only way you can do that is to make it very clear that an academic case has to be made and it is not unreasonable we should be making a clear case as to why a particular case should be referred. At the moment obviously the extra-contractual referrals make a case which is based on the clinical need. I think we have to make a case based on the research need. If you can do that and there is a way of that being judged by appropriate individuals it should be possible to set a scheme in motion.

Lord Perry of Walton

1022. More referrals are based on the principle that the money must follow the patient. Is it possible to reverse it in the case of research referrals of that sort extra-contractually by providing the money direct to the receiving hospital to pay the costs? In other words you avoid having any particular charge on the referring trust.

(*Professor Edwards*) That is what I mean by having a separate sum identified which could fund those.

Chairman] The problem that the government might raise is that that might mean taking us back to separate funding of the special health authority hospitals in London which are now being compelled to enter the internal market.

Lord Butterfield

1023. Can I ask whether the Secretary of State seemed to be moved by the cases she heard about at the meeting with the Wellcome?

28 February 1995]

PROFESSOR GRAEME R D CATTO, PROFESSOR PETER HOWIE,
PROFESSOR C R W EDWARDS AND PROFESSOR BRIAN WHITING

[Continued]

[Lord Butterfield *contd.*]

(*Professor Edwards*) I think she was. I think she recognised no amount of health service research was going to effect the long-term future of people with diabetes, for example, or patients with Alzheimer's disease. There has to be a balance between basic research and health services research.

(*Professor Catto*) My Lord Chairman, there may be a chink of light here. Within Scotland there has been co-operation between the genetic laboratories so that the tests for Huntingdon's Chorea and so on are not competitively organised but are done on a shared basis throughout the country. Funding has been made available for that. That type of professional-led development may be the way forward.

Chairman

1024. In some parts of England there are some research beds funded on a recurrent basis from non-NHS sources, drug companies and charities, a very limited number but they exist. Are you aware of any in Scotland and what is your idea on the principle?

(*Professor Edwards*) We have in Edinburgh 20 beds which are funded in that way. They were funded as part of a contract with Syntex Pharmaceuticals and enabled us to set up a clinical research facility. The funding for that was approximately a million pounds per annum. That contract has just come to an end and the university has decided that it would wish to continue with that facility and so we will be having separate contracts with a number of individual drug companies in order to carry that on. I think this has been a very successful venture from our point of view. It has not only been beneficial to the company because it has a high quality of facilities available to it for drug evaluation but it has also resulted in us getting a first class research facility for the investigation of new drugs. I think there has been mutual benefit and it is certainly something I would support.

Lord Perry of Walton

1025. You would regard a number of research beds, not used by the drug companies but for general purpose, as a good thing?

(*Professor Edwards*) Yes, I think in the increasingly cost conscious world that we are living in, if there is no hedge that you can put round a particular area and say that is going to have a special emphasis on research, more and more research will be displaced.

Chairman

1026. Would you like to tell us about the joint planning between the university, the Edinburgh Royal and the Western General hospital and would you like to give us any lessons to take south of the border?

(*Professor Edwards*) I think there does appear to be a closer relationship between the universities and the NHS in Scotland than in England and Wales. This may reflect size rather than anything else. At the national level the Scottish deans and the Chief

Medical Officer have a regular meeting, as does the Scottish Home and Health Department, with the Scottish principals and deans. We also have at a local level a well-established series of liaison committees which enable the university to relate to the health service and to the trusts. I feel that the reason our planning has proceeded perhaps in a more orderly way is that we have had this close relationship. As far as the question of Lothian's acute services strategy is concerned that has now resulted in plans for a new Royal Infirmary and an enlarged Western General hospital. The situation we have reached at the moment is that those plans are clear and the university has gone through an option appraisal to identify its response to that strategy. I think where the difficulty arises, and of course this is a national difficulty, is how do you fund the academic part of that development? What I would hope would be the case is that we could recognise some of the principles that appear to be being established down south, namely if universities are displaced from NHS accommodation because of an NHS-led need for a new hospital that the NHS would be responsible for the costs of replacing the academic space. At the moment that principle does not seem to be being applied and we certainly are having problems with how we proceed with the whole of the strategy. The very particular point here is that Edinburgh Royal Infirmary and the Western General hospital are being pushed down the private finance initiative route and at the moment we are really in difficulties because the university of course is going to almost certainly go down the same route.

1027. I think it does vary a great deal south of the border. I think there are areas where collaboration has been quite outstanding. I look back to my own period in Newcastle-upon-Tyne where the regional health authority and the other health authorities and the university worked in extremely close collaboration with what they called one teaching hospital on three sites. Even there it is interesting that when we were planning a new medical school with an adjacent new ward block it was so planned that there were academic university departments in part of the ward block and NHS departments in the medical school; at the end the then university grants committee and the regional health authority decided to split the costs of the development fifty/fifty between them. It worked extremely well. The only thing that went wrong was that the planning criteria were very different, the UGC measured to the inside of the party walls whereas the NHS measured to the middle of the party walls. The result was that when the plans were complete the medical school, one or the other, proved to be 1.5 per cent over area. You know how these things happen. Even so I think that collaboration is to be recommended.

(*Professor Whiting*) Can I say, my Lord Chairman, we are about to enter a similar intensive planning stage in Glasgow focusing on the future of the Western Infirmary. The same issues will apply there as applied in Edinburgh, how we move all the embedded accommodation from the Western Infirmary to the existing site at Gartnavel. It will be tremendously helped by a Joint Planning Team between the University and the Health Board, also

28 February 1995]

PROFESSOR GRAEME R D CATTO, PROFESSOR PETER HOWIE,
PROFESSOR C R W EDWARDS AND PROFESSOR BRIAN WHITING

[Continued]

[Chairman *contd.*]

including representatives from the Western and Royal Infirmarys.

1028. One of the strengths of national planning in Scotland in the past, and one of the strengths of regional planning in England, has been that it has been possible to concentrate highly expensive tertiary referral facilities in a very limited number of centres. One danger that one sees with the increasing development of independent trusts is that some of them might be tempted to follow the American idea of every hospital having its own transplant unit or having its own neuro-surgery or cardio-vascular unit. Is there any risk that the independence of the trusts might lead to such problems?

(*Professor Edwards*) The question is a very apposite. To put it in sharp focus Edinburgh Royal Infirmary will be Edinburgh's major accident and emergency department. The Western General will be where neuro-surgery is performed. Not surprisingly the Royal Infirmary would wish to have neuro-surgery in relation to its trauma. What has happened here is that the Health Board has played the key role in saying no and insisted that neuro surgery will be at the Western and trauma will be at the New Royal. They have said it will be inconvenient but they will have to work together. Provided the health board as purchaser plays a lead, and it is a firm role, you can sort these problems out.

(*Professor Catto*) Perhaps I might intervene there slightly. It is helpful as long as the health board is the primary purchaser. As you move to a situation where GP fund holders obtain more and more of the money that type of sensible central planning becomes very much more difficult to organise.

Lord Butterfield

1029. I was very distressed to gather that a school which I had always regarded as like a magnet to iron filings for overseas registrars may be having or could have difficulty in the future getting overseas registrars to fill these vacant spots that may turn up. Is it really true that overseas interest in registrars is drying up and that there is no way in which posts can be filled in future for a short period?

(*Professor Edwards*) I think there has been worldwide change in the pattern of staff movements. What is happening, of course, is that, not surprisingly, individual countries that used to send a lot of their medical staff to the United Kingdom have now developed their own facilities. They may even have developed their own examinations. We have to recognise that this has meant they wish to retain their own staff and may not be sending so many staff to the United Kingdom. All we are seeing is the consequence of those local movements.

1030. Can any of you give us any lead about what it was about your Chief Scientist Organisation that got our Department of Health interested in setting up what turned out to be Professor Peckham? It does seem to me it is possible some Scot implanted the idea of the Peckham development in a mind south of the border which has had a very large effect. That would, of course, be very strong evidence of the success of your Chief Scientist Organisation. I just wondered whether there was any anecdotal evidence that

people have been watching you and saying, "We must have one like him or her."

(*Professor Edwards*) It would not surprise me but it is not known to me.

Chairman

1031. Our predecessor Committee chaired by the late Lord Nelson was the body that made the primary move towards establishing Michael Peckham's employment in England. I think the Scottish example was a very good one to follow and of course there was a Chief Scientist, Sir Douglas Black, before that in England who had a powerful influence.

(*Professor Howie*) We are happy that the ship of research and development is launched but we are also very concerned about who is sailing the ship. In Scotland we feel if the Chief Scientist is the captain there would be a lot of confidence among the academics because I think the Chief Scientists have been people of particularly high calibre who have commanded the confidence of the medical schools.

1032. The last question on the paper was dealing with intellectual property rights and charities. My understanding is that that issue, that was giving concern following a earlier paper from the Charity Commission, has now been essentially resolved in that there is no longer any implication of charities being in any way responsible for the R&D necessarily undertaken with grants from themselves, or is that not the case?

(*Professor Edwards*) I have seen the evidence that was given to you by the Chairman of the Scientific Committee of the Wellcome Trust earlier with regard to the Wellcome Trust's attitude towards intellectual property rights and the Trust is forming a joint company with the Cancer Research Campaign. The Charity Commission recommendations are currently being discussed with the Trust and are confidential and, as such, I have been told we cannot discuss them with you.

1033. The other anxiety we had in the past about the charities being held responsible for the research, that issue has been resolved?

(*Professor Edwards*) That was clearly ludicrous. Obviously I think we were all particularly concerned at the possibility of governors of the Wellcome Trust being required to read the output and being totally responsible for all research being funded by the Trust; that was clearly impossible.

1034. We have seen some contracts in England drawn up relating to research to be conducted in major hospital institutions with funding from the NHS R&D budget which have included a clause requiring notification before dissemination, meaning that the Secretary of State has been required to examine the output and the results of research before it can be published. Are you aware of similar requirements in any contracts in Scotland and what would be your comments if there were such?

(*Professor Edwards*) I am certainly not aware of any in Scotland. I am sure I speak for all of us by saying we would feel that would be a major retrograde step. Clearly that is moving in the direction of a commercial contract and I think it is

28 February 1995]

[Continued]

[Chairman *contd.*]

not in the nature of science and it is not in the nature of scientists that we should try and prevent communication, and certainly as far as charitable bodies are concerned one has to recognise there is an absolute imposition on the trust to make sure that the

results of any research that is funded are communicated and so to restrict communication would be against that.

Chairman] Thank you very much.

Examination of witnesses

PROFESSOR ANDREW WYLLIE, Department of Experimental Pathology, and PROFESSOR RONA MACKIE, Department of Dermatology, University of Glasgow, Fellows of the Royal Society of Edinburgh, were called in and examined.

Chairman

1035. Professors Wyllie and Mackie, thank you very much indeed for coming and for being willing to talk to us. What is your impression of the initiatives toward developing an NHS R&D strategy for Scotland which have been taken by the Chief Scientist Office since 1993 and how do they compare with the initiatives taken south of the border by Professor Michael Peckham?

(*Professor MacKie*) Thank you. We have, of course, the publication by the Chief Scientist Office on the research and development strategy which I take it you have received a copy of. This is very much looking at the restructuring of the system for Scotland and putting a lot of emphasis on 12 priority areas. This has been accompanied by a number of changes in both the naming and to a certain extent perhaps the stated aims of the funding bodies that work from the Chief Scientist Office. We used to have a bio-medical research committee which is now an acute health care committee looking at funding R&D. There has perhaps been a little bit of a change in approach there in the eyes of some members of that committee in that there is a great emphasis at the present time on funding projects which have a very immediate impact on diagnosis and therapy. This, of course, can be very difficult, as I am sure you are all very well aware, in terms of knowing at the beginning of the project how quickly and, indeed, how relevant it may be. One of the phrases given to it by a colleague recently was that they were interested in projects which would have an impact on diagnosis and therapy within the lifetime of the award. As many of these awards are for two or three years at the most that is of course quite a tall order and perhaps not always in the interests of the more innovative and what Paul Williams refers to as "serendipity related activities". That is a little bit of a cause for concern but in some of the other areas obviously there is a great emphasis on trying to implement the findings of projects which have been funded by the committee relatively quickly. Historically here and south of the border, and it is not peculiar to the United Kingdom, there often is this long lag-time between being aware of knowledge and putting it into clinical action. There is obviously a great enthusiasm and concern for doing this more rapidly. I think at the moment it is difficult to point to examples of this happening as yet but there is a great appetite for doing it. One of the other areas where I think there has been a slight change recently is that because of the funding for the human genome project there is now less

enthusiasm—in fact it may be a policy and I am not sure if it is written policy—that genetic related projects are not so readily accepted by some of the acute health care committees which is giving some who have got some interesting projects at the advancing edge of genetics and its impact on patient care cause for concern. Obviously some of these are not clearly fundable through the human genome project. Perhaps there is a little bit of a vacuum in that area at the present time.

1036. It has been put to us there has been a significant change between 1992-93 and 1993-94 in that much more money in the CSO research grant budget is now going into health services and public health research and also into operational research than into acute health care research where the funding appears to have been reduced by about £700,000 per annum. Is this a cause of concern to you and your colleagues?

(*Professor MacKie*) Yes, it is. As far as the Society is concerned it is a great cause for concern because as we stated in the document we prepared for you there is a great determination on the part of this Society to try and encourage what we refer to as curiosity-driven research and there is a great concern that is going to be a little bit inhibited and stifled by the current policy. I think that is a difficult area to fund at the present time.

(*Professor Wyllie*) I would like to expand a little on that in that I think there has been a tendency in the past, if I can take up this area of the impact of molecular genetics, where most of the growth has been in the recent past in the understanding of a number of socially significant diseases. If we take up that issue in the context of our discussion, this is an area where I think by tradition one imagines that the clinical implications will be quite a long way away and therefore the funding should be fairly heavily polarised towards research councils. I think that probably was the case up to five years' ago but the speed of advance is such that is no longer the case. A whole series of very significant projects are now becoming possible like identifying within the context of the National Health Service who is going to be particularly susceptible on the basis of genetics to common cancers. That is now a completely feasible proposition but it does require finance at the population level. It requires very substantial finance and that would be a novel departure for any health service really in this country to be able to use this sort of technology to target cancer screening procedures. Now I think whatever one may argue about the ethics

28 February 1995]

PROFESSOR ANDREW WYLLIE AND PROFESSOR RONA MACKIE

[Continued]

[Chairman *contd.*]

or the additional problem of having information about cancer susceptibility, it is a big issue, it is an advance, it is a change in the way we manage health care which is proportionate to the knowledge we have. I would contrast that type of approach as a legitimate funding option with the sorts of things one can do with health services research. I am not a health service researcher but I have been in some of the committees in the MRC and what I noted whilst I was there was that first of all there was great difficulty in finding projects which were of sufficient excellence to be fundable at the level of the people sitting round the committee table of the MRC and, secondly, that all of these projects by nature of their subject of interest were the measurement of the status as it is at the moment. Why are we not applying new technology? Is it a question of economics? Can we do a comparative health economics evaluation of one mode of analysis versus another? What are the opportunity costs? They all measure the situation as it is at present. You need just one major advance and the whole of the equation is changed. I would have thought there was an almost philosophical reason for maintaining the funding for the innovative type of research and its applications which are close now to the bedside.

Lord Perry of Walton

1037. Are you arguing that if you have a diagnostic test in the sense of a test that will determine susceptibility to some disease or cancer, that ought to be paid for by money which is outside the ring-fenced research budget, out of the routine funding of the National Health Service?

(*Professor Wyllie*) There is a problem because what we are speaking about is the launching of almost population based genetic screening and that is going to be an expensive output. It does not look like fundamental research so the councils will not pick it up. It is not the sort of the thing you can do within £50,000 two year grants from the Chief Scientist Office. It will require some form of targeted funding yet it is the way you would apply the advances of the recent past.

Chairman

1038. You are talking about screening, for example relating to the genetic basis of breast cancer. If you are to do a population screening survey are you classifying that as health services research or bio-medical research?

(*Professor Wyllie*) I would have thought the people who like to define health services research would not include this in their definition.

1039. I am not sure. It is an epidemiological survey and screening which in the view of certain people would come within health services research.

(*Professor Wyllie*) So long as that is understood that is fine but I think for most people this is not health services research.

(*Professor MacKie*) There does seem to be an argument here in terms of the first test, which is of course to assess whether or not screening is going to be worthwhile. This is a problem not peculiar to

Scotland but at MRC level there is clearly a difficulty in picking up the additional clinical costs that go along with these projects. This is a terribly important area just now because very quickly we are moving from the molecular laboratory stage to the country as our laboratory in terms of assessing the value of screening and that is not easy to do in terms of who is going to pick up the additional clinical costs.

1040. I would say surely that devising the test, developing the technique and validating the test is bio-medical research but once it has been validated applying it to the study of populations, surely that is health services research?

(*Professor MacKie*) I agree. I think the problem there is the very word "validating", is it not, because to validate it you require a clinical population. That is the point at which funding is very difficult to come by. It is the actual validation before it moves from one area to the other. It is the grey area in the middle.

(*Professor Wyllie*) We are at that interface now for breast cancer and colon cancer.

1041. You have welcomed the Culyer report's proposal that the terms on which the NHS provides service support to external funding bodies should be reviewed. You mean external funding from bodies such as the MRC, the charities, the Cancer Research Campaign, the British Heart Foundation. We wonder why you feel this should be reviewed.

(*Professor MacKie*) What has been happening, again speaking of personal examples, in Scotland is that with the new trusts finding their feet and settling down I think it has to be said that in many trusts the climate for supporting research is lukewarm at best. The trusts often have rather more pressing things on their agenda. A good example, which does not affect either of our own personal research fields, was a very large MRC clinical research initiative awarded to Glasgow in the field of cardio-vascular research, a big project, £6 million. This was awarded on the basis of joint collaboration between basic science in the university buildings and 200 yards away the clinical aspects in the NHS Western Infirmary, now one of the trusts in Glasgow. There have been on-going problems in terms of the new fledgling trust, which has only been in existence for a year, it began in April 1994, actually accepting some of the responsibilities for, first of all, an area that needs worked on in Scotland in terms of our history of cardio-vascular disease and, secondly, a very meritorious thing to have won against strong opposition, and it has been very sad to watch the difficulties that my young colleagues in cardiology have had in getting the trust to recognise it had some obligation to not just support but to welcome this extra funding and to offer a little space for it and offer something in the way of service provision. If these obligations of trusts in the case of grants and awards like this were more clearly laid down I think some of the on-going problems could have been avoided. That is my specific answer to that particular question. Other colleagues will be putting together a document with similar examples. I do not think the trusts—and in Scotland remember our trusts are a year behind the England and Wales trusts—have really decided how committed they are going to be to research. Lip service is perhaps paid rather than genuine

28 February 1995]

PROFESSOR ANDREW WYLLIE AND PROFESSOR RONA MACKIE

[Continued]

[Chairman *contd.*]

enthusiasm even in the trusts that are very much involved with the teaching hospitals.

1042. I take it then that you are not proposing that charities should be required to pay overheads to hospitals in the NHS. Are you prepared to accept that the same kind of principle that has always been followed in the past, that the infrastructure should be provided by the NHS and direct costs only paid by the charities, is one that should pertain?

(*Professor MacKie*) I would have thought very much so and I think other members of the Royal Society would feel the same. I do not like the term knock-for knock, I prefer mutual benefit. Clearly having that kind of research climate around is very beneficial in my view to NHS colleagues and to patients.

1043. It has been suggested by Culyer that before a research grant proposal is submitted which involves the use of NHS service support, for example a research project involving patients in NHS hospitals, this should be signed off by the NHS authorities in much the same way as the universities now require to sign off a project grant application before it goes to a body such as the MRC or a charity. What is your view of this proposal of signing off by the NHS?

(*Professor MacKie*) The term signing off is not attractive. I think one has to be realistic and live in the real world and if one is involved in projects that are going to involve patient care and additional investigative costs, simple things, at the moment, and again we can speak with experience, access to medical records can sometimes be surprisingly difficult in terms of long-term follow up projects. I think it is a good idea to make chief executives aware of the potential added activity this funding may generate but also to try to create a climate in which this is regarded as highly desirable because it is—

Lord Perry of Walton

1044. Do you think in terms of the concordat with the MRC that a trust could in fact refuse to sign off?

(*Professor MacKie*) I would have thought if you were a trust that comprised a teaching hospital it would be very difficult to do that without seriously questioning your existence as a trust. I would be very surprised if that could be refused but equally I do think in the past there have been problems with communications in terms of—I am not defending this approach at all—I think if one is going to be looking at large numbers of patients in a large project it is wise for the trust to be aware this could be an additional cost—very often it is a problem of space rather than actually funding extra staff—and knowing what could be involved in terms of having to accommodate it. They should welcome it as something which is highly desirable to bring to their hospitals.

1045. I was not for a moment suggesting they should not be informed.

(*Professor MacKie*) Information rather than signing off. Sensible consultation.

Chairman

1046. Supposing you were wishing to carry out a major clinical trial of treatment for, let us say, psoriasis on an out-patient basis and you were applying for a research grant which would give you a research assistant who was clinically qualified to help and other necessary supporting staff and you took this to the trust and the trust said they could not afford the time of patients or outpatient clinics necessary to carry out this project, what would be your reaction?

(*Professor MacKie*) I would not expect it to happen and I think nowadays one can do an awful lot with fund holding GPs. It would be very easy to conduct that study from a large practice but, equally, I think working from an academic base that if one hospital had this attitude I would approach another hospital. This can be done in the community. I do not think we would just fold up.

1047. What about funding within the actual hospital and trust concerned?

(*Professor MacKie*) Obviously there would be a lot of talking before one went elsewhere. Equally I think most trust chief executives at the present time, speaking for the ones I know, are fully aware that today's clinical trial is tomorrow's best therapy and guidelines and would not do that so I would not expect that to happen.

Lord Butterfield

1048. Can I go back to that cardio-vascular study which has been launched without any question of signing off but I got the impression it was not going very well from the point of view of the young clinicians involved in the trial.

(*Professor MacKie*) This is bigger than just a trial. I think the problem has been, again in fairness to the trust, that this initiative went in pre-trust. This covered the period before the hospital became a trust. I think there has been very real and recognisable frustration on the part of clinicians that the trust has been slow to recognise its responsibilities. It has not negated them but has been very slow to pick up the clinical end of the project by contrast to the university end where it has been very quick and things have moved on rather rapidly. Obviously the two things work hand in glove. That is the whole idea, as I am sure you know very well, of these initiatives and the clinical end is holding back the more basic scientific end at the moment. I am sure it will come right but it has been a rather difficult and slow six months for them.

Chairman

1049. Does that trust have a non-executive director representing the university?

(*Professor MacKie*) Yes, indeed, and he has been vocal but it has taken longer than you would expect.

28 February 1995]

PROFESSOR ANDREW WYLLIE AND PROFESSOR RONA MACKIE

[Continued]

Lord Butterfield

1050. This is interwoven with the question about it proving difficult to sustain patient flows for research. I gather that there are two ways in which this might be upsetting things with you. One is agreements were signed before trust status had arrived and were not fully understood but to what extent is the flow of patients being impeded because the purchasers do not want to purchase high quality care as offered by research units and teaching hospitals when this case could be taken care of in a smaller hospital less expensively without reference to the high powered centre? Do you have that problem in Scotland?

(*Professor MacKie*) Not personally as yet but one of the references we gave you in the main document was to some of the problems the United Kingdom Co-ordinating Committee for Cancer Research (UKCCCR) have been experiencing which they published in the British Medical Journal last August. The lead author in that is John Smyth who is professor of clinical oncology here in Edinburgh. I think there is concern in some areas that there has been perhaps a fall in the referral rate of some of the rarer malignancies. This would not apply to some of the commoner problems. Again the other problem he quotes in that publication is the fact that within the hospitals themselves it is not just a worry about the referral but many of these clinical trials are, of course, carried out by NHS-paid staff at least in part. With the changing climate in the NHS, the changing rotas for young clinicians, there is a tremendous lack of time to do very worthwhile studies that will further young NHS-based clinicians' careers. There is a problem in terms of junior time and possibly a problem in terms of referrals. I think again the onus is on academic centres to prove their approaches to therapy are to the patients' benefit. In the cancer field that is happening quite quickly and referral centres are quite quickly going to be the norm rather than something one has to justify.

(*Professor Wyllie*) In response to your question I think the laboratory services might be particularly anxious about the sort of situation you envisage where funds might be switched by the purchaser from what was an academic unit to a non-academic unit. It is very easy to do these sums that make the provision by, say, a private laboratory look enormously cheap relative to the provision of a laboratory service which is also training junior staff. That is a hidden cost which if unpaid for ten years crashes the service.

Chairman

1051. We have heard from a professor of pathology who is in charge in England of a major department concerned with soft tissue oncology and the diagnosis of rare cancers. He has given us evidence to suggest that in that particular field the number of specimens which used to come to him from all over the United Kingdom for his expert opinion was substantial but that under the new NHS arrangements the number referred has been very much fewer. Have you had experience similar to that?

(*Professor Wyllie*) I do not think we have yet had experience of anything similar to that but the anxiety is very real. I think it would be true to say that the

private sector is less developed in Scotland than it is in England.

Chairman] This was not private; these were in fact referrals from other consultant oncologists in the NHS who were sending difficult specimens to him and, of course, their managers were complaining about the cost of referring these.

Lord Nathan

1052. You said that you are anxious about it; why are you anxious?

(*Professor Wyllie*) I think I am anxious because if the academic units cannot secure the workload they lose the posts and then they cease to be academic units.

Lord Perry of Walton

1053. If there was a special provision made for extra contractual referrals, whether in pathology or cases of clinical departments, would you prefer that it was made available through the normal practice of the money following the patient, in other words the money would be provided specially to the referring hospital trust and paid by them to the receiving hospital trust, or would you prefer that the money was made available to the receiving hospital which was the research based hospital so they do not have to charge the referring hospital?

(*Professor MacKie*) It is difficult to quickly respond to that. I would have thought a lot in this situation must depend on the base clinician and the base pathologist in charge of the individual patient making a clear case for specialist referral. I would have thought the funding ought to stay at base and then follow the patient, that way round, otherwise bases are going to be denuded. The other point Andrew has made as well is one of the things, if you look at the United Kingdom tradition—and this applies to the whole country, not just to Scotland—both in the clinical and laboratory based pathology world we have got a good tradition of gathering a cluster of rarer diseases and from looking at the group, rather than one or two over a couple of years, producing information which is useful to that particular condition and it seems to me that if this kind of money following the patient or the specimen, it does not matter which, whether it is soft tissue oncology I know about too, and it is an important area and unless people look at clusters of these rare conditions we are not going to advance our knowledge. Applying the newer molecular techniques to one sample is nothing, to 20 samples you can perceive a pattern. The short answer to your question is my inclination would be to leave the money with the purchaser with an onus on the academic department to show it can do something useful with it. I think that is a better way to do it. You might disagree.

(*Professor Wyllie*) I think the arguments are pretty evenly balanced, are they not, because you could argue also it would be a very good way (if we go along with some of the other Culyer recommendations and try to be a bit more proactive) of fostering centres of excellence in certain areas.

(*Professor MacKie*) It would be very difficult to break in. You can imagine one designated very good

28 February 1995]

PROFESSOR ANDREW WYLLIE AND PROFESSOR RONA MACKIE

[Continued]

[Lord Perry of Walton *contd.*]

soft tissue laboratory in the country but if a new up and coming soft tissue oncologist wanted to build up his own area of expertise it would be very difficult to do it from that background.

1054. I could not agree more that the impetus to refer has got to come from the referring clinician. But he is working with the manager who has got to okay the payment that is required. It may be that he, to maintain good relations with the manager, would prefer to have it done locally. If there was no charge he would not be so inhibited.

(*Professor MacKie*) I think if you take a sensible case to managers they listen and I have so far not found managers unreasonable. I think again medical education for managers is very important. A lot of specialties, whatever subject it may be, may run days for managers (and I do this in my own field) and they are very useful days because all sorts of misconceptions are blown away in the end from both sides. We find ourselves more sympathetic to managers and vice versa. I think that kind of communication should be fostered.

Chairman

1055. Do you think that process of training should not just involve managers but also the lay chairmen of health boards?

(*Professor MacKie*) Very much. They are often very aware of where their lacks of knowledge are and are very happy to.

Lord Butterfield] I think we have touched on perhaps one of the things you can do so well in Scotland and we would find more difficult in England. You might be able through the Royal Society to ensure that managers and health care administrators were brought to appreciate the extraordinary reputation research has brought to this country. Please make sure that the people being brought into hospitals as managers newly appointed are brought up-to-date either by some publication or by meeting here at the Royal Society and getting a feeling for what the intellectuals have done for Scotland. You are a country with a remarkable history of intellectual contributions from Scots people in science. I would hope you capitalise on that and make sure there were not these difficulties we are all worried about that the managers do not understand what the scientist is trying to do.

Chairman] I was taught in my medical student days by a Scottish surgeon who worked in Newcastle who said to me one day, "My boy, why are tuberculosis glands in the neck like Scotsmen coming over the border?" "I don't know, sir," I said. He said, "Whenever you find one, you find another one behind them."

Lord Perry of Walton

1056. You may not realise just how lucky you are in being able to trust your managers as far as you can. It does not happen everywhere.

(*Professor MacKie*) I think when one travels around the country one does realise at the moment communication is on the whole quite good in Scotland and groups like the Royal Society can foster

that in terms of excellent one and two-day meetings promoting this exchange of views; of that there is no question.

Lord Nathan

1057. I was wondering the extent to which provision is made in Scotland for research from charitable sources.

(*Professor MacKie*) Are you discussing specific Scottish charitable sources or national charitable sources?

1058. I am talking about the receipts by those who are in the position you are in of being concerned with National Health Service activity in the research field.

(*Professor MacKie*) It is the spectrum of charitable research based activity in Scotland?

1059. I do not mind whether the charity was created and collects its funds in Scotland or collects its funds in England, I am interested in their use here.

(*Professor MacKie*) In terms of the areas I can speak to very quickly; the Cancer Research Campaign, for example, has large well-funded laboratories in Scotland that form the basis of the Beatson Institute Cancer Research which is an international very well-respected and recognised activity heavily funded by CRC. In addition there are a lot of three and five year project programme grants. We have ICRF units. With the British Heart Foundation again a lot of competitive money comes into Scotland. I would have thought Scotland competes fairly happily for charitable money at the present time. Money is raised here and goes to central sources very often but I think by and large the Scots get back just as much as they raise. My impression is we do quite well for charitable money.

(*Professor Wyllie*) I would agree with that. I do not know if this reflects more on the Cancer Research Campaign or on Scotsmen but it is repeatedly said that the Campaign spends more money in Scotland than it gains from Scotland.

(*Professor MacKie*) On the strength of competitive applications.

(*Professor Wyllie*) But I think there are slightly idiosyncratic elements in some of the charities in that they have a strongly local feel to them. I suppose one cannot control that but even within the broad umbrella of the Cancer Research Campaign there are regional variants of that campaign in the north of England. It is my impression that it is a little bit easier to raise charitable funds from that sort of source than it is against national competition. Maybe one should just accept that and be pleased with it.

1060. There are only ten per cent of the population paying into charities but four out the 22 medical schools and therefore—

(*Professor MacKie*) There should be a lot of grant applications, absolutely.

Chairman

1061. We heard this morning there are in Edinburgh 20 research beds which have been paid for in the past by a drug company which has covered all of the recurrent costs of funding those beds

28 February 1995]

PROFESSOR ANDREW WYLLIE AND PROFESSOR RONA MACKIE

[Continued]

[Chairman contd.]

specifically for research purposes. Are you aware of any other situations in Scotland where there are research beds or indeed research outpatient clinics which have been funded from NHS sources or external sources?

(*Professor MacKie*) I tried to find out more about this for you from centres other than Edinburgh and Glasgow. It is common at the present time for many of the clinical pharmacology projects to have as part of the funding from the relevant pharmaceutical company very often to support a five-day investigation unit for the duration of that project but these are not beds that are funded in perpetuity but perhaps for a few years to my knowledge by one specific company. Certainly speaking for my own teaching hospital there is a small suite in a clinical investigation unit which is funded fairly sequentially by one project after another from different pharmaceutical companies. From that point of view there is a little, but not constant funding. In other words patients who were being investigated purely for the purpose of a trial would not be occupying a bed that would otherwise be occupied by a patient who was in for other reasons.

1062. When the trial ends what happens to those beds?

(*Professor MacKie*) What seems to happen at the present time obviously there is good medical management here and a new trial begins. It is a roll-over arrangement and seems to work very well.

Lord Butterfield

1063. I am very pleased to hear that those beds are being maintained in Scotland. When I was a professor of experimental medicine long ago at Guy's hospital I sensed people were not very happy when I said we would take a couple of people who worked at Wellcome, the drug company, to do research with us. There was an awful feeling that that was dirty money. I am very pleased to hear you have got good relations with your pharmaceutical colleagues.

(*Professor MacKie*) I think there is a fair relationship in which both sides get what they need to get in terms of knowledge, in terms of their product, in terms of physiology and physiological changes. It seems to me on the whole it is an equitable arrangement at the present time.

Chairman

1064. If the Culyer proposals to ring-fence the R component of SIFTR in England were to be followed by the ring-fencing of the R component of ACT in Scotland it has been put to us it might be appropriate to put that into three separate funding streams, that one stream should be centrally controlled from the Director of Research and Development in England or from the Chief Scientist Office in Scotland, and should be used to fund nationally agreed priority-driven research in the broadest sense including operational research; that a second stream, which might be quite modest, could be used to fund biomedical research at a local level which would be the responsibility perhaps of committees on which the research and development officer of the health board

(who has to be appointed) might be involved. That would be comparable to the locally operated research scheme in England and would give the opportunity for young people to take their first steps in research. The third and major stream would be funding for the infrastructure of clinical research and funding for facilities for research in hospitals across the board with the proposal that the formula which dealt with such funding would ultimately become based on research assessment like the HEFC. Do you have any comments upon that suggestion?

(*Professor MacKie*) I have heard suggestions of this type. It would depend an awful lot, in my view, on who decided on these nationally agreed proposals and again what proportion went into these various groups. One can see some advantages in some nationally agreed proposals but equally authorities change quite quickly and there would have to be a good degree of consultation before they were agreed upon. Again it depends so much on the sum one is discussing. If there is plenty for all that kind of provision is not too much of a worry. If, as is normally the case, research money is less than demands placed upon it becomes very important what the fine tuning of the relative proportions are.

Lord Perry of Walton

1065. What you mean is that there would be a national determination of a proportion that would go to the facilities funding and infrastructure but that it would be distributed locally according to need?

(*Professor MacKie*) Yes, but there would be nationally agreed priorities which would be funded.

1066. Simply keeping it out of the health services research distribution, which is a very important function for this money, but is a separate issue altogether.

(*Professor MacKie*) I think on the whole, trying to speak on behalf of the Society, the important thing would be that the R component of ACT were kept for genuine research, not just for minor underpinning if you like, but funding to genuinely support at least some curiosity-driven research and some slightly longer-term projects. I think that would be a very important view speaking for Fellows of the Society. The problem with a big proportion being taken down to local level is one would have to be very cautious that it was not slightly frittered in the structure of a laboratory area and the money for actually doing the work vanished. I think that would be my great concern when we get down to local level.

Lord Butterfield

1067. I would like you to talk more about your philosophy about research having some responsibility for future thinking and research which is backward looking. Is that really research or literature review?

(*Professor MacKie*) I would regard that as review or audit depending on whether you are reviewing the more technical things. Surely research is stepping forward into what is not yet known, in my view.

1068. It is an interesting point.

28 February 1995]

PROFESSOR ANDREW WYLLIE AND PROFESSOR RONA MACKIE

[Continued]

[Lord Butterfield *contd.*]

(*Professor Wyllie*) It is difficult to avoid lapsing into anecdotalism of the sorts of things I have seen happen. Maybe you will excuse me giving an example or two. A lot of money was spent on health economic evaluation of various magnetic resonance imaging technologies for examination of head injury and a range of different conditions. It was all good, it was all well-intentioned but one technical development and all the sums are wrong. I think what was lacking was a commitment to apply the technology. If we address head injury or gall bladder stones or nephrolithiasis by a series of different routes and conduct a very careful evaluation over five years of all the opportunity costs and the health economics, by the time you have finished the study people are doing what they want to do anyway if they have got the funds and if they do not they do not do anything anyway. The impact of this has been surprisingly little. I cannot think of very many tremendously good examples where this type of health services research has had a major impact (I do not think there is any doubt about the definition here; this is mainstream operational research with good economic evaluation and a lot of colour in it).

1069. A professor of community health at Cambridge went out to see exactly how much it cost to have a heart transplant. He was astonished to find how very cheap it was despite what the local newspapers were saying damning this work when there were old people with sticks who needed their hips replaced. So I am personally fascinated by your differentiation between bookkeeping research as opposed to thinking research.

(*Professor Wyllie*) I like the terms you have used. I am sure both are necessary but it is the balance that worries me. When one is running a health service there is obviously an intrinsic bias towards the bookkeeping side.

(*Professor MacKie*) Everyone needs research development and then integration into standard care in terms of the peripatetic example because people tend to think because it is in the literature it will be acted upon but that is not the case. Here again we come back to, in terms of managers and purchasing education, pushing back best standards of care in making sure this happens.

Chairman

1070. What are you going to tell us about the ways in which academic clinical medicine can be revived and its quality maintained into the next century?

(*Professor MacKie*) I think we in Scotland have a problem as you have in England at the present time, as I perceive and understand it. There is no doubt in the fairly recent past, I would say over the past five years and certainly over the past decade, there has been a change in what is expected of both junior and senior academics in terms of volume of work and a lack of time really to do the curiosity-driven new research. There is a huge amount, as you very well know, of things like the research assessment exercise which, albeit a sensible idea, generates a vast amount of additional paperwork for senior colleagues. For junior colleagues a lot of the traditional time for research is now taken up with straightforward

clinical care. Clinical audit has been put in as a necessary and essential part of both junior and senior clinical activity. I have no objection to clinical audit but it takes time and done well it takes a surprising amount of time. That has also been fitted into the normal workload. It is not a question of time being set aside for this. I think many junior colleagues looking at the senior academic life at the present time and the volume of extraneous activity which is required as distinct from the clearly perceived teaching research and clinical duties which should form the trail, do not see the academic way of life as a terribly desirable one; they see it as a rather fraught one with a huge amount of paper work and are perhaps less enthusiastic than one would have liked them to be. I think that is very sad, I really do. I think at the present time in some specialties, it has not yet happened in my own, the best people are choosing not to pursue or stay in an academic career. It is very obvious in some surgery specialties that they are moving out. I do not think it is all financial. Obviously this has to be touched upon. I think a lot of it is looking at what the workload of a senior academic comprises and perhaps feeling this is not quite the balance we would like. We do have to do something about it or we are going to lose the next generation of good senior academics who bring the juniors up.

Lord Perry of Walton

1071. Do you not think the workload for senior service consultants is going to get far bigger too because of the total reduction in the back-up support from the honorary registrar appointments that the universities used to provide and, indeed, the reduction in the senior registrars and registrar grades?

(*Professor MacKie*) As we see the implementation of the Culyer report and the specialist training grades with the emphasis moving towards an almost American system of people doing a very definite training programme rather than the apprenticeship system which we have been more used to in the United Kingdom, we are going to see, particularly in some fields such as anaesthesia for example, a heavier work load pushed back on to senior colleagues. It is possibly slightly easier for senior colleagues in the NHS to say this much and no more and step aside and drop a session than it is for the academics. I think it is a problem common to both streams of activity. The other thing I regret is that until recently, certainly speaking from my own teaching hospital, there has been a very muzzy divide between those paid by the universities and those who are paid by the NHS. The type of approach, the type of activity is similar but over the last five years it has been very clearly divided because of the desire of trusts and the need to be accountable. I think that is a pity. We have had some excellent people funded by the NHS doing very good clinical research in the past. It is going to be increasingly difficult for them to lead that kind of lifestyle. They contributed very much and I think it is a pity we are now so clearly divided into university-funded and NHS-funded. I think the loose divide was a much healthier arrangement.

28 February 1995]

PROFESSOR ANDREW WYLLIE AND PROFESSOR RONA MACKIE

[Continued]

[Lord Perry of Walton *contd.*]

1072. I do not disagree at all but do you not also think the fact the universities are not going to be able to employ lecturers with honorary registrar posts in the health service is going to destroy the base of academic clinical research in the universities?

(*Professor MacKie*) I think it is going to endanger it. In terms of the more active departments there will always be bright young people who are happy to come into funded posts for three years and do a good bit of work in its own right which also gives them the necessary qualifications whether they require an MD or perhaps a PhD and then gives them a real feel for academic life. Even if they decide not to proceed and go back into the NHS it gives them a sympathy for these activities. These people will still exist but again the way the whole system is moving at the present time it is going to be increasingly difficult for new departments to establish this kind of pattern. What is happening at the moment is not too damaging for those who are already established but it will be very difficult for people to build up something new at the present time. That is very sad.

Lord Nathan

1073. That is a very important statement.

(*Professor MacKie*) That is my personal view and I think in terms of looking at funding authorities and approaches it is a true one.

1074. Professor Wyllie's statement placed great emphasise on the importance of doing so. What you are advising us is that the present structure stands in the way of achieving it.

(*Professor MacKie*) I think the present structure makes it more difficult than it was five or ten years ago, yes.

Chairman

1075. When I worked in Newcastle one of the most disastrous clinical areas in relation to teaching and research in our university many years ago was dermatology so the university actually at that time funded a chair because they recognised that the right thing to do to develop the speciality—

(*Professor MacKie*)—was to bring in a good person.

1076. So we got John Ingram and later we got Sam Shuster, both of them well-known to you, so now it is one of the liveliest departments in that particular university. With the same aim there has been a major development across the whole of United Kingdom towards the funding of chairs and senior lectureships from NHS money in order to raise the standing and development of training and research in individual specialties, some of them relatively minor, which had not had in the past academic development. Do you see the future in Scotland being dependent upon that mechanism? Alternatively would you look at the possibility of more so-called A plus B appointments of people with, say, two or three university sessions and the rest in the NHS? Would you wish to have more NHS-funding of senior lectureships and lectureships to maintain that ladder in the academic field?

(*Professor MacKie*) My personal view on this would be first of all that A and B appointments are not common in Scotland; they are relatively rare. I think they are sometimes a little complicated as a hybrid in terms of where people's loyalties lie. My personal view would be they are not the answer. The funding of chairs, as you say the Newcastle dermatology scene is a good example—and the latest one, Jonathan Reece, is as good as his predecessors. The funding of a chair is alright as long as it is underpinned. I have seen some chairs funded really changing the name of the individual's job. That really does nothing. It has to be a chair with a little bit of backing in terms of laboratory space and secretarial funding. From that base an able person will go out and get funds. If someone who is doing a heavy NHS consultant job is called "professor" next week with no change, it does not work. There has to be more than just a label there. If there is genuine commitment towards establishing an academic department with a chair I think that is a very good way to proceed. I think it is important for the NHS to realise individuals may want to spend some time as clinical lecturers or senior lecturers and they could go back and forth easily between health service posts and academic posts and again, in my view, this would add to the strength of NHS activities in that area. Again I would like to encourage the NHS to fund the junior posts to try and keep the interchange going at all levels, akin to the MRC funding at every level.

Lord Perry of Walton] I am right in thinking there are a lot of people who move from the academic world where they were lecturers on MRC or other grants to doing a pure PhD? A lot of them have been going back into pure service jobs in the NHS?

(*Professor MacKie*) Absolutely.

1077. There are not many people who become senior lecturers or professors with honorary contracts who subsequently move back into the NHS, are there?

(*Professor MacKie*) Not very many. I think I have seen a few examples of a senior lecturer going back to the NHS in some of the surgical specialties recently in Scotland but not often; it is usually at the junior level.

1078. Once you become a pure academic at the senior level you stay?

(*Professor MacKie*) Yes.

1079. I wholly agree with you about the futility of funding what we used to call naked chairs, chairs without support.

(*Professor MacKie*) It does not work.

Lord Perry of Walton

1080. As far as I can understand from the evidence we have had heard so far, Scotland has about 22 per cent of all its senior academic clinical appointments funded by the NHS compared to up to 60 per cent I think in Leicester. Do you regard that as a happy situation or an unhappy one?

(*Professor MacKie*) One can only speak for what one knows. It seems to me that there are certain areas of clinical activity which are very appropriate for the Health Service to fund. Some of the chairs of public health and primary care medicine seem to me quite

28 February 1995]

PROFESSOR ANDREW WYLLIE AND PROFESSOR RONA MACKIE

[Continued]

[Lord Perry of Walton *contd.*]

good examples. Other areas are appropriate for the universities to fund. I think one has to look at the balance of activities. I would have thought 60 per cent is a little high. It seems to me there are certain areas of academic activity which have more immediate bearing, going back to the R&D example, on NHS activities and should be funded and in some cases at the moment are not funded by the NHS. Those are areas where one could press for more research funding and putting it into permanent posts and there are other areas where it is perhaps not appropriate to pursue that analogy.

Chairman

1081. Another point which is relevant, which is comparatively recent in England, has been in certain major centres with hospitals of distinction which do not have medical schools, that the NHS locally has funded chairs and senior lectureships in order to create post-graduate schools. This has happened at Keele, Hull and in one or two other centres and in some other regions where there is a medical school posts have been funded through the NHS such as chairs and senior lectureships in the periphery because many medical students are now going out to the regional hospitals. Has there been any such development that you are aware of in Scotland?

(*Professor MacKie*) Not the establishment of full academic posts, certainly speaking for Glasgow, where we cover the whole of the west of Scotland in terms of our under-graduate teaching. We now have sub deans in hospitals well outwith the main centres but these are honorary appointments, not full scale. The new curriculum is going to bring this very much into focus. There is going to be a need to look at either academics being a bit more peripatetic and prepared to perform some of their clinical activities outwith the main teaching centre in terms of maintaining collaboration with colleagues. I think that is important.

Lord Perry of Walton

1082. Do you think it is a more stable situation than it would be if most teaching jobs or a large number of them were funded by the NHS?

(*Professor MacKie*) I would have thought it was a very unstable situation if there is a lot of the NHS funding of teaching jobs because if the NHS hits hard times I would have thought that individuals would be under very heavy pressure to pick up a much heavier clinical load than appropriate. I would prefer the academic freedom of university-funded posts.

Chairman

1083. Although, of course, one of the reasons why the NHS stepped in to do so much funding is because the universities have had their funding cut.

(*Professor MacKie*) Better an NHS-funded post than none at all but I would prefer the university-funded ones.

(*Professor Wyllie*) The case can be well made that the NHS get a very good bargain out of providing funding to a chair of the sort you have described

because all the value added staff begin to appear if things go well. That brings not only reputation but people and eventually patients and we hope the trust is involved. Could I say something about the environment and training of more junior staff just in passing? I have been silent because I have been listening with great admiration to my colleague and agreeing with everything she says but I think also in thinking back to the good old days we should remember there are important advances in the academic structure today which were not present in the past. One of these is the fusion of skills which were not intrinsically medical with medical skills. That is something which is relatively new which at the level of sophistication of training it is difficult to pick up in a few weekends or a year's sabbatical. I am thinking of molecular genetic advances. That carries in its wake the implication that areas that are active in research and academic activity related to medicine will tend to become centres of excellence of a rather distinctive character where scientists and medically trained people are working together in a custom built laboratory. It is a rather different scene from the hired post-doctorate worker on soft money grants inside a clinical department. With the greatest respect that was the general pattern 20 years' ago. I think we have to see that the development of Institutes is the way things will develop and therefore if the funding base can be organised so there is flexibility and the junior clinical staff can get into that sort of institute without prejudicing their future. In other words they must have an entry point and a return point assured back into an more directly clinical post. That will create the sort of environment where the technology transfer, the information transfer, the experience, the ethos of being in a research environment can be maintained. I think our fear is that what can be done, should polarisation develop between what is service and what is research, would have a different ethos from what I am talking about. If research becomes what you do to further your personal career it is unlikely to produce much of value.

1084. This does bring up the whole issue of the Calman proposals on the future training of junior medical staff where the whole period is to be reduced and every registrar in training will be given a number. Supposing that individual wishes to go into an academic career, we are told they will retain that number; they may then move out for a period of three years to do a PhD in an institute of the type that you have discussed, and will carry that number with them when they go back into subsequent academic work. It means effectively that they will have to spend an additional three years or so in that pattern of training. What do you see as being the likely effect of this process upon the future of academic medicine?

(*Professor Wyllie*) The fact that a person falls back by three years in a world which is very competitive?

1085. Yes.

(*Professor Wyllie*) Obviously I think it is a very bad prospect because young men are picked because they are, whether we like these emotions or not, ambitious and thrusting and they want to get on. If part of their process of getting on is to ensure that they must stay within a ladder, I think it is difficult to ask them to leave it. There are altruistic individuals who love to

28 February 1995]

PROFESSOR ANDREW WYLLIE AND PROFESSOR RONA MACKIE

[Continued

[Chairman *contd.*]

do research and probably they will always do it but there is also a lot of untapped excellence which we can use.

1086. Will there not be a disincentive from their parent department because when an individual leaves that registrar post it can only be filled by a visiting registrar?

(*Professor Wyllie*) That was the point I was wishing to raise as well, not just the re-entry of the individual but the retention of the post so that the departure of talented individuals to do research should not compromise their parent departments.

1087. How can that be overcome?

(*Professor Wyllie*) I am afraid it means more posts.

(*Professor MacKie*) I have here the working party report on the unified training grade, the consultation document with Graham Winyard's name at the bottom. It is very interesting to read that in the context of the questions you are asking us this afternoon. It is very much aimed at four years in many cases, through and out, but of course the exit point is going to be questionable by contrast to the current system where people gently diffuse into jobs as they become available and can stay in a senior registrar post for quite a while until the correct post for their particular skills becomes available. It would seem to me perhaps it is not quite as gloomy as has been suggested in that it is going to be acutely important for these people at the end of their training to be very well qualified otherwise the possibility of a period of less employment, shall we say, looms. I would have thought there might be more enthusiasm than perhaps has been suggested for equipping oneself as well as possible for the best jobs. I am perhaps an optimist and I hope that this is the way it will work out and people will be happy to step aside and do research. I think the numbering thing is a great pity. I would have thought that while you are doing a pure research job the number should be allocated elsewhere but you should retain the right to come in again. The important thing is to allow re-entry which we have at the moment before we bring in the unified training grade where able people who could, and in some cases have been offered, for example, MRC training fellowships, are so concerned about the competitive nature of coming in again they are nervous and throw away a wonderful opportunity. I think that is very sad indeed. I do not think the unified grade implementation document is yet sorted out and I would push very hard for encouraging a sensible period of time but during that period of time making sure the parent body is not in anyway damaged otherwise, as you say, senior colleagues will not be keen to see them go. It is going to take a bit of thinking out but it really is to everyone's advantage to think that research period out better than is in this document at the present time.

Lord Perry of Walton

1088. I have seen all these papers and done a lot of thinking and their diagnosis of the problem is superb.

(*Professor MacKie*) But they have not got a solution.

1089. No, and they are sympathetic to the idea but none of them has a clue about how to solve it.

(*Professor MacKie*) I think it is solvable. I would have thought one does have to accept it takes longer than they are allowing if research is recognised as part of one's training, not as an optional extra. I think it should be in terms of subsequently appreciating research, not necessarily subsequently doing it, but understanding what is going on.

1090. The question is whether you need three years of research in order to appreciate and comprehend research results or whether you only need one, which is what they are talking about, whereas if you are going to be a research worker in an academic department you are going to need more than one.

(*Professor MacKie*) I think one year nowadays in terms of the variety and speed of development is a pretty fleeting glance and I would like to see more than one.

Chairman

1091. It does imply for those stepping aside from the training ladder to take, say, three years to do a PhD there must be an adequate number of posts at the end, whether those senior lectureships are funded by the universities, the NHS or by a charitable organisation such as Wellcome, the British Heart Foundation or Cancer Research Campaign.

(*Professor MacKie*) There must be some degree of confidence that they will be wanted at the end.

Lord Nathan

1092. Is there any experience in Scotland of endowment of chairs by the charities, the CRC for instance, who started chairs in oncology?

(*Professor MacKie*) The CRC funds our chairs of oncology in Glasgow, for example, one on clinical oncology and one on radiation oncology. There also have been recent personal endowments. We now have a chair of palliative medicine as a result of a very major endowment from a recently deceased medical person.

1093. Do you think that would be a more fruitful source of funds for chairs, particularly in newer disciplines or new combinations of disciplines?

(*Professor MacKie*) I think there are some fields where the relevant charities make it entirely feasible and possible. Rheumatology is a case in point where the kind of funding needed is available and I think is a good idea in terms of developing. Some of the newer specialties perhaps have not got the necessary charitable bodies behind them to raise the funding. In some cases, yes; in others it would not be realistic to expect it to emerge from that source.

Lord Perry of Walton

1094. I take it you mean by funding, providing an endowment?

(*Professor MacKie*) Providing a really solid endowment so that chair is funded plus support in perpetuity.

28 February 1995]

[Continued]

[Lord Perry of Walton *contd.*]

Chairman] I remember that when I was a dean in the 1970s you could endow a chair and a lectureship and a secretary in perpetuity for £120,000. Not only could you do that in those days but that individual was then added to the university establishment and when along came an annual salary award, the individual's salary, like all others, was supplemented centrally by the university grants committee. Universities are now asking for £1 million as a minimum to endow a chair. That is the problem. It is a question of the magnitude of funding that is required. The principle is outstandingly good but the actual practicalities have become difficult.

1095. You mentioned the increasing number of occasions when you had non-medical as well as medical people involved and this is different from the situation in the purely clinical departments, significantly different in scale. Does this mean that the person seconded from clinical medicine to do three years in one of those laboratories is less burdened by routine because there are enough people at the non-medical level to carry that out than would be the case if you went to a true clinical department?

(*Professor MacKie*) I think for many of the junior colleagues who are taking time out to work in a laboratory, departmental barriers are coming down quite quickly, with shared core laboratories at the moment and shared staff. I have two senior lecturers

in a small department who are non-medical scientists. There is a lot of sharing of molecular medicine facilities and laboratories so the kind of environment these people are going to be in is very healthy. There are a lot of scientists and a lot of young people but very often the people there on funding from various bodies taking time out could come from four different departments from gynaecologists to dermatologists. That kind of thing is going on all the time. I think that is very healthy in terms of cost of current molecular biological techniques, using good core laboratories which are doing high quality work high rather than cheeseparings in one corner of an old lab belonging to one department. That does not work so well nowadays; it is better to collaborate.

1096. I should have realised I was out of date.
(*Professor MacKie*) Not at all.

Chairman

1097. Thank you very much indeed for sparing the time.

(*Professor MacKie*) I have put together some of our responses to the additional questions you asked us last week.

Examination of witnesses

DR R E KENDALL, Chief Medical Officer, and PROFESSOR I A D BOUCHIER, Chief Scientist, Scottish Office Home and Health Department, were called in and examined.

Chairman

1098. Could I just say how grateful we are to you for sparing the time to come and talk to us.

(*Professor Bouchier*) I welcome the opportunity of being here because it is an important time from the point of view of the Chief Scientist Office. You have had the document on the research and development strategy and that together with the Culyer report and the manpower review committee have important implications for how we take research forward in Scotland and I hope we will explore those this afternoon.

1099. What progress have you made toward implementing your R&D strategy since the annual report 1993/94?

(*Professor Bouchier*) I think we have done a number of things. First of all we are very aware that we must keep up the momentum and so we have created two groups. One is the Implementation Group and the other is the Strategy Group. The Implementation Group is a very large group chaired by Mr Banks and it is to do with the review of how the strategy is put in place at a local level so it has a very large membership and it is exploring first of all what strategy is being implemented and identifying problems therein and, of course, trying to identify where the gaps are. Then there is another much smaller committee or group which I chair, Dr Kendall is on it, as are members of the policy division

and also the management executive. That is really to look at strategy do make sure the R&D strategy is working, in particular to identify the priority research which we will then take forward to develop the strategy as time goes on. We want to see this as a continuum. What we do not want is to have one document and then a block and then another period of time before deciding on priorities. In addition to that we have an initiative in nursing research for Scotland. We have taken forward an initiative in primary care and community care. We have taken forward an initiative in mental health and in a number of other areas as well. We think the strategy is moving forward in the direction that was set out in 1993.

1100. One of the things that struck us looking at the figures from your annual report is that the balance of CSO support is shifting from acute health care research towards health services and public health research and operational research. There has been a substantial change in the allocation of funds. How far do you intend to take this shift?

(*Professor Bouchier*) In part, of course, it is obviously part of our strategy, our philosophy, that we see the need to reinforce research and implementation of research in the health services area. So that is a deliberate attempt to move more money to that sector. I think we should qualify that quite strongly. First of all the figures that you see also reflect money that we spend on our units and our

28 February 1995]

DR R E KENDALL AND PROFESSOR I A D BOUCHIER

[Continued]

[Chairman *contd.*]

units are related not only to health services research but they also have another function. The second thing is that the quality of health services research has improved and therefore we are in a position to fund much more health services research that we would have liked to have funded five years' ago but could not. I suppose finally the Chief Scientist Office is totally committed to maintaining a base in acute health care, bio-medical research, totally committed to opportunity driven research, which of course applies to health services research as well. I see this in the end being a balance with a shifting line between the two depending year in and year out on the quality of applications that come through. While we do not have a figure in mind we are agreed within the Office that acute health care should not be overlooked at the expense of health services research.

1101. Have indicators emerged to confirm the success of your R&D strategy or the value of any particular research programme that you are supporting?

(*Professor Bouchier*) I believe so. It has only been in progress for a year and a half at the most. It came out at the end of 1993 but all the health boards and most of the hospital trusts have expressed a commitment to the R&D strategy. They have taken the trouble to appoint lead officers with the specific remit to put in place research and development within trusts and health boards. Many of the trusts have already developed a profile of their research so that we are already on to a list of research in health boards and in trusts related to the R&D strategy. I think there is quite a lot of evidence that it has been taken seriously.

Lord Butterfield

1102. To what extent do you think that the structural arrangements underpinning the NHS R&D strategy in England are consciously modelled on the Scottish system?

(*Professor Bouchier*) I would like to think England took some note of what was happening in Scotland and took the best bits out of Scotland and used it to good effect in England.

1103. Would they have a means of doing that in the way things are run between Edinburgh and London?

(*Professor Bouchier*) Yes, CMO will bear me out in this. There are very good communications at officer level, government level. CMO and I are frequently talking to people in London so they would be aware of what is going on.

Lord Perry of Walton

1104. We have got a summary of three different papers that our Clerk prepared for us and I wanted to check he has got the facts right. It looks as if in Scotland the ACT component is about £30 million

(*Dr Kendall*) Total ACT in Scotland this year is just under £94 million, which works out at something over £42,000 per clinical medical student.

1105. In that case we have got it all wrong.

(*Dr Kendall*) The total of ACT is £94 million this year.

1106. And three quarters of it is the T component?

(*Dr Kendall*) We have never decided because we never had the data to decide what was spent on what. We have noted that England have decided 25 per cent of SIFTR is for research but we have not made any formal decision that the same is true in Scotland because we did not have an empirical basis for making such a decision.

Chairman

1107. We were told earlier today there had been a study by Price Waterhouse which suggested something like a quarter was being spent on research.

(*Dr Kendall*) The Price Waterhouse study was commissioned by the four teaching boards and unfortunately it included post-graduate teaching and the biggest single chunk of the money, as Price Waterhouse covered it, went on post-graduate teaching. They actually calculated that under-graduate teaching was 25 per cent of the sum and research was also 25 per cent of the total sum. That can be interpreted in two ways. It can be interpreted as 25 per cent of ACT goes on research. It could also be interpreted, if you leave out the post-graduate teaching which ACT is not really meant to cover, that the amount which is going on research is approximately equal to the amount going on under-graduate teaching.

Lord Perry of Walton

1108. 50 per cent of the £94 million is post-graduate teaching?

(*Dr Kendall*) They broke it into several different components and they distinguished between post-graduate students and registrar training but the two together were the biggest single component.

Chairman

1109. In England, of course, post-graduate vocational training for doctors and GPs is separately funded and is not part of SIFTR. Were you including the funds for post-graduate teaching in your 1994 plan?

(*Dr Kendall*) This was a decision taken by the health boards, not by the Scottish Office. They asked that this should be included. As I am sure you know, the origins of SIFTR and ACT are very obscure; it was just the excess cost of teaching hospitals and nobody knew what it went on. It was a fairly arbitrary decision that this was the excess cost of teaching and, of course, teaching hospitals do do a disproportionate amount of post-graduate teaching as well as under-graduate teaching. I think the decision that 25 per cent of the sum went on research by the Department of Health again did not have a very robust empirical basis, although I think that the Department of Health statisticians were satisfied that it was not incompatible with any of the data which they had.

28 February 1995]

DR R E KENDELL AND PROFESSOR I A D BOUCHIER

[Continued]

Lord Perry of Walton

1110. I do not think it is very robust in England either.

(*Dr Kendell*) I was referring to England because we have never ourselves attempted to put a figure on it.

1111. The other figure in the table that we have is that in 1993/94 you had £9.7 million available for CSO research grants.

(*Professor Bouchier*) That is correct. It has gone up since then. I think our spend now is going to approach £11 million.

1112. Of which £6.7 million in that year was for health service and community research, if you add everything except acute health care?

(*Professor Bouchier*) I would need notice of that because it depends on how you interpret it. If you add all the units together you actually are lumping some of the work which could be classed as acute health care. I do not know that you can do it quite as simply as that, my Lord.

1113. The reason I am asking it, let me come clean, we have been considering the possibility that the whole of the R budget now talked about in the report, part of it will be distributed by Doctor Peckham centrally, part of it will be distributed through the DRDs, in your case yourself, for what your priorities are; part of it is what is called "facilities fees", which would be said to be based on the assessment exercise rather than student numbers. That was the R component of SIFTR. We wondered whether it would be wise to separate off these two bits of local provision into the facilities needs, which can be distributed directly, rather in the same way as the T component is already distributed, leaving the rest to be distributed by the DRDs, by yourself, for your local priorities.

(*Professor Bouchier*) I can understand that approach. We are still at the stage when we are discussing how we might use ACT R money. We have not identified that money and we have not yet got close to identifying how it should be distributed. You have probably read there is a committee which has been established recently under the chairmanship of Dr Kevin Woods, Director of Purchasing and this committee will be considering it. My concept of how it might be done is that the Chief Scientist Office would be involved in identifying the best way of monitoring and administering the research spend but the calls for that research spend might come from the Management Executive, might come from the Policy Group, might come from health, but the process of administering the research would be through the Chief Scientist Office because we have the expertise. Whether it is broken down very precisely along the lines you have suggested, I think will depend on the circumstances in Scotland because in Scotland we do not have the equivalent of the large regional health authorities so it would have to be a different system. I think whatever happens it is correct to say there would have to be a local spend which would be determined by the local health board or trust hospital. I think what we would be concerned about is two things; first of all that the quality of research is good, it is not money wasted and, secondly, that all research that is being done is identified under the Project Register System so we do have a proper perspective of what research is being done in

Scotland and there is not going to be undue repetition because the problems on the whole from one health board to another and one trust to another are likely to be very similar. I would see the role of the Chief Scientist Organisation as having a monitoring role under that system. Whether we have a very clear-cut clean distinction along the three tiers you have suggested will depend on when we look at the detail of how best it is to administer it. What I would have thought at this stage is it would be unhelpful to have too rigid compartmentalisation whereby you are not able to shift money across depending on circumstances.

1114. What was bothering me was, the research assessment exercise we hope will be done in association with the HEFC system will only apply to teaching hospitals and to other hospitals used by the medical schools for teaching or research and it will not apply to any other part of the health service?

(*Professor Bouchier*) You are talking about Scotland?

1115. I am talking about the research assessment exercise.

(*Professor Bouchier*) In Scotland is it the research assessment exercise that SHEFC has done or are you talking about the assessment of research that Culyer mentioned in his report?

Chairman

1116. Culyer did talk about research assessments and the general impression we have had from a whole series of witnesses is that it would be a great mistake to set up a separate research assessment exercise and that anything done about research assessing in the NHS should be done in collaboration in Scotland by SHEFC or in England by HEFCE.

(*Professor Bouchier*) I agree.

Lord Perry of Walton

1117. If that is done the facilities that are necessary to support that research, which would be the R component of SIFTR, could only be sensibly provided to those institutions which had been subjected to the research assessment?

(*Professor Bouchier*) Yes, that is true although, of course, it is not difficult to expand the area using the mechanisms that have been done but at the moment the amount of R money going to non-teaching boards and hospitals is really very small indeed.

1118. I am aware of that.

(*Professor Bouchier*) I think that is correct.

Chairman

1119. The thought has been put to us that there should be three streams, one which is centrally operated from Professor Peckham, for example, or in your case your Office, which deals with national strategies as far as overall research is concerned; a second stream which would be handled from your Office but some might be delegated to local individuals concerned with R&D and the individual boards which are going to be established. What we are concerned about is whether they will continue to

28 February 1995]

DR R E KENDELL AND PROFESSOR I A D BOUCHIER

[Continued]

[Chairman contd.]

make regional funds available from this source for low cost opportunistic or feasibility studies or for people to take their first steps in research as happens in England under the locally operated clinical research scheme. Are you intending that such mechanisms will still be available and will that help to provide the research opportunities that Lord Perry is concerned about in the non-teaching hospitals?

(*Professor Bouchier*) Let me respond to the question and let me explain why I have to qualify what I say. As Chief Scientist my organisation is totally committed to local research, curiosity research, even commissioned research. Local research should take place. From one or two of the comments you have made, my Lord, I should clarify the situation of the Chief Scientist Office in terms of its spend of money compared with the spend of money in health services research in Scotland as a whole. We have a budget of £11 million which my Office spends on research in the way identified. There is a large amount of money still being spent which currently is held in the management executive over which we have absolutely no input in terms of how it is spent and how it is monitored. If your suggestions are to take place, and I believe they are sound suggestions in principle, then the Chief Scientist Office would have to be integrated more into decision making in research spending within the management executive than it is at the moment. At the moment we have no input into that aspect of research spend. We would like to feel we could play a role in helping research being spent along the lines of the R&D strategy.

Lord Perry of Walton

1120. Is that not the first stream that Lord Walton was describing, what we call the centrally-operated Peckham money?

(*Professor Bouchier*) I do not believe we can break it down in exactly the same way because Michael Peckham is involved in co-ordinating research spend between management executive and local regional health authorities in England. I have no such role in Scotland. I have a budget that comes to me through the Health Policy and Public Health Directorate. I have a budget which comes to me but I do not have any inter-action with the money spending which takes place through the management executive.

Chairman

1121. Or in the local health boards except when you fund a unit?

(*Professor Bouchier*) Yes, that is correct.

Lord Perry of Walton

1122. None of the Peckham money comes to Scotland?

(*Professor Bouchier*) No, unless it is a project which has been agreed beforehand in which Scotland plays a role and it is a national project.

(*Dr Kendell*) Some Scottish research workers have bid for Peckham money and got it. It does not come to Scotland to be spent in Scotland. It only comes to

Scotland if the best bid for a particular study which Professor Peckham is interested in happens to come from Scotland.

1123. Is that not true of any region in England?

(*Dr Kendell*) Yes, but it means—

1124. It means as far as that is concerned you are treated like any other region?

(*Dr Kendell*) It means that Hadrian's Wall is fairly low!

Chairman

1125. The NHS in England has set a target for R&D of 1.5 per cent of its total budget. Have you had any similar targets set in Scotland?

(*Dr Kendell*) Our Secretary of State, my Lord, has never committed himself. We did have some preliminary discussions but very quickly decided, as we did not know how much we were spending at present on research, that we could not sensibly set a target. If we assume 25 per cent of ACT money is for research then we are spending about 0.85 per cent.

1126. To that you have to add what Professor Bouchier is spending?

(*Dr Kendell*) I am including that. If we were to assume, which is not implausible, that 50 per cent of that money actually goes on research (I do not think that is wholly implausible) we are almost at 1.5 per cent already.

1127. Does that mean the £11 million, as the budget says, is part of ACT?

(*Dr Kendell*) No.

1128. I just want to be clear on that.

(*Dr Kendell*) The way I was doing the sum is this. Our total NHS budget at present is £4.1 billion. If 1.5 per cent of that were to be devoted to research it would be £61 or £62 million. We have Professor Bouchier's £10 million and then a variable fraction of ACT depending on how much.

Lord Perry of Walton

1129. Do you think it would be a good idea if post-graduate teaching were included in SIFTR in England? Are you better off with ACT because it includes post-graduates?

(*Dr Kendell*) I cannot answer that question. The trouble with this money is that everybody regards it as theirs. The medical schools regard it as theirs. When I was a dean I was very keen to get my hands on it. The local teaching boards regard it as theirs. Post-graduate deans regard it as theirs and nobody really knows what it is for. It was simply the excess cost of teaching hospitals.

1130. How is it distributed?

(*Dr Kendell*) It goes to the teaching boards in proportion to medical student numbers.

1131. All of it?

(*Dr Kendell*) All of it goes to the teaching boards in the first instance.

1132. All of it is based on student numbers?

(*Dr Kendell*) It is all based on student numbers and it is a little over £42,000 per clinical student. A small

28 February 1995]

DR R E KENDELL AND PROFESSOR I A D BOUCHIER

[Continued]

[Lord Perry of Walton *contd.*]

amount of that goes to the university departments of general practice specifically for under-graduate teaching in general practice. A small amount also goes to peripheral health boards to at least contribute to the cost of the medical students whom they train.

Chairman

1133. Can you tell us about your research project register?

(*Professor Bouchier*) We are just getting that underway. It is obviously part of the information strategy system which, as you have probably heard, is linked to the Cochrane Centres and the Centre for Reviews and Dissemination. In Scotland we have started in two ways. First of all we have a complete register of all the projects which have been funded by the Chief Scientist Office and that is available to anyone in Scotland and abroad of course who wishes to see what research is being done and has been done.

Lord Butterfield

1134. How many items on your register?

(*Professor Bouchier*) I cannot answer that.

1135. Hundreds?

(*Professor Bouchier*) I would hope so. We fund a lot of projects throughout the year. That is projects funded through the Chief Scientist Organisation and these are easy to identify. We are now trying to identify what projects are funded through local trust money and local health board money. A start has been made in Grampian. We are in the process of completing a register of all projects funded in Grampian. Once we know how that exercise pans out we can expand it to the rest of Scotland. That is a project which began last year and it is in the process of moving forward.

Chairman

1136. You are not including at the moment MRC and charitably funded research?

(*Professor Bouchier*) We would include all projects. The idea is to have a total review of all projects and that is what we would have in Grampian, MRC funded projects as well.

Lord Nathan

1137. I wondered how successful your efforts have been in carrying out research in the primary care and community sectors which are becoming so increasingly important because of short stays in hospitals and people are put out into community care.

(*Professor Bouchier*) Again this is early days in terms of our strategy. As you correctly say, we recognise the importance of this area of research. It is very difficult and it is difficult because the issues to be dealt with are not as clearly defined very often as they are within a hospital sector or in a laboratory and many of the people working do not have the expertise in research which you have within a medical school teaching hospital situation. We have made

advances in two aspects. We have made a particular effort to try and involve primary care at a general practice level, starting from a base within the teaching practices for medical schools and the evidence is that since the R&D document and the strategy have been announced that there has been an improvement in the quantity and quality of research being undertaken from the teaching practices, bigger grants, more grants coming to them. That is a start and one expects that to diffuse out beyond teaching to general practice in general. We have made a particular effort to work with the nursing aspect of primary care. We have the nursing research strategy just beginning to get underway. We have appointed a director of the nursing research unit. We have just discussed how that unit will function. It will function very much as a unit without walls, a small central base, but with lots of outstations where research will be done within the community looking at issues which are directly related to patient care and welfare in the community. It will be multi-disciplinary so it will not just involve nurses; it will involve all the other individuals involved in health care. I think that on the basis of these two we hope that we are making progress. As I said at the beginning, progress is difficult. I think it is important to stress that we are very conscious, like in England, of the need for training people in research. That is not only training the medical profession but training the nursing profession and other people to develop a capacity to undertake research.

1138. How far have you brought into this aspect of your work other disciplines within the universities?

(*Professor Bouchier*) I think health service research par excellence is a multi disciplinary topic. I suppose sociologists—one of our research unit works very closely with sociology and social policy—statisticians, psychologists, economists particularly. I think now it is almost impossible to get a health service research grant unless you have an economic aspect there. All of these disciplines are recognised. I think the difficulty is that the paradigm of health service research has not been sufficiently established. A lot of disciplines are wary of interacting with health when they could be interacting with other more dramatic circumstances as we have seen in the last day or two. It is difficult to get economists involved but we try to.

1139. I think that is a matter of interest for the reason you mentioned; the techniques for carrying this out have not been explored yet.

(*Professor Bouchier*) I think that is where we believe the Health Services Research Unit and the Health Economics Research Unit are so important in bringing in expertise, other disciplines and mixing them up within a unit structure of doctors, medical graduates and other types of graduates working together on the question of a health related topic.

Chairman

1140. Have any of your research fellowships gone to health practitioners or nurses?

(*Professor Bouchier*) Most go to nurses and a fair number go to general practitioners.

28 February 1995]

DR R E KENDALL AND PROFESSOR I A D BOUCHIER

[Continued]

[Chairman *contd.*]

1141. To what extent are you intending to apply the recommendations of Culyer to Scotland?

(*Dr Kendall*) I think we accept the central recommendations that it makes sense to have a single stream of research funding and that this should be conceptualised as top-sliced money off the total health care budget. We are also very aware that it would cause great difficulty for national bodies like the Medical Research Council if we had a radically different system. A very large number of trials are multi-centred across the country. Of course, Culyer was an English report to the Department of Health and any proposals which Dr Woods' working party finally comes up with would have to go to our Ministers for agreement; but it is certainly our starting intention to work along the same basic principles as Culyer and to end up with a system which is compatible with other parts of the United Kingdom.

1142. One of the issues which is giving us great concern is the whole problem of recruitment to and advancement in clinical academic medicine. We have noted that a substantial number of academic posts, both at junior and senior lecturer level, are funded by the NHS in Scotland, although not quite to the extent that is the case in certain regions in England. Is this something that you would hope to see continuing and if so is there going to be a difficulty in having these funded by individual trusts or is there a mechanism by which they can be funded in some way more centrally?

(*Dr Kendall*) At present we do not have exact figures for how many university posts are funded by the National Health Service because it is almost entirely a matter of local initiative. There are only five posts, all in public health medicine, funded directly by the Scottish Office. But we estimate from the returns from the teaching boards that there is something of the order of 80 consultant level academic posts in Scotland and 20 something training posts, mostly clinical lectureships, and probably overall something around ten per cent of clinical academic posts in Scotland are funded by the NHS. Whether that will continue to be so we do not know. Most of these posts became university posts in the first place funded with NHS funds because the local health authority was convinced that it would be able to recruit somebody of higher calibre in this way. I would hope and expect if they continue to have that expectation they will see it as continuing in their interests. Certainly so far there is no hint at all that trusts are anti-academic.

1143. We noted of course with interest your report on distinction awards. At the moment it is clear that the government has not made up its mind as to what is going to happen. You made the recommendation that the lowest C awards would be a matter for local decision. We wondered whether that would disadvantage younger doctors aspiring to distinction in academic research or was it your intention that those developing a distinguished career in research in clinical medicine might jump directly to the B grade?

(*Dr Kendall*) My Lord, I must start by saying in self-defence it was not my report; it was a report of a committee which I chaired and which the government did not accept, although I believe that it

is the basis of negotiations at present between the government and the medical profession. If the report had been accepted I think it is inescapable that the emphasis on research would have been somewhat diluted, simply because there was bound to be an increased emphasis on management skills and contribution to the management or running of the hospital. For the same reason there would be a somewhat reduced emphasis on clinical excellence. How much that would matter, how great the effect, would have been impossible to tell until the system was up and running. I think that remains the case. We certainly recommended a loophole whereby it was not necessary to have a C award before getting a B award, and that of course is the case at present, but we envisaged that this would be fairly infrequent.

1144. Because young clinical academics have said because of the emphasis on local contribution to the Health Service it has become increasingly difficult to get a C award.

(*Dr Kendall*) I cannot comment on that. I am not in a position to.

Lord Perry of Walton

1145. All the reports that we have had, and I have read about the new unified training grade that is being introduced in the NHS, have indicated that to get a numbered post you have to be making your way straight through and they all pay lip service to the possibility of taking one year out and have it count on the seven years, as it were, in research but if they want to do a PhD and spend three years there is going to be a problem because of how they are replaced. They all pay lip service to the need to feed the academic stream for university posts in the end but they have not got any suggestion how it is to be done because they will not allow honorary posts in the registrar grades to be held by university lecturers.

(*Dr Kendall*) I hope that a lot of these fears will prove to be misplaced. I think a lot of the apprehension is simply because nobody knows yet what the new system will be like. It might make research easier; it will certainly shorten the duration of clinical training, probably by two years per specialty on average. That ought to allow more time for other things and I think it is explicit that trainees can take time out for research before they become a specialist registrar or during that time—and the health departments have recently obtained counsel's opinion that there is nothing in the European Directive that makes that impossible—or indeed after they have finished their specialist registrar training and they have got their CCST before they become a consultant. I think much in practice will depend on the attitudes of the colleges and of the post-graduate deans. I do not see anything in the basic structure which discourages research.

1146. Why should the dean of Edinburgh medical school have to get rid of 30 lectureships because he cannot give them honorary registrar status?

(*Dr Kendall*) I think Edinburgh is in a slightly unusual position in that it has an awful lot of lecturers in medicine. That is not a general problem throughout Scotland and it is not a general problem throughout other disciplines. In any system, if it is to

28 February 1995]

DR R E KENDALL AND PROFESSOR I A D BOUCHIER

[Continued]

[Lord Perry of Walton *contd.*]

be planned at all, the number of people in training must be matched more or less to the consultant level jobs that are going to be available at the end of the day.

1147. It must surely also include the honorary consultant jobs? At the moment I understand it does not.

(*Dr Kendall*) At the moment the system does not exist so we do not know, but it certainly should take into account the future need for university posts as well as the future need for NHS posts.

Chairman

1148. One problem we have been told about is that the new registrar would have a number and if he or she moved out, say, into a three year research project to obtain a PhD that number would stay with them and the post would be kept open for them to go back to. In the meantime that post could not be filled by a specialist registrar, only by a visiting registrar. Do you foresee this causing difficulty?

(*Dr Kendall*) I do not think any decisions have yet been made about that because the final report of the working party on academic and research medicine has not yet been published, although I think its publication is imminent. There is no reason in principle why there should be a problem.

(*Professor Bouchier*) I agree with everything Dr Kendall has said but I have to confess an anxiety about the current state of affairs and the reason for this is that if things do not work out then there is going to be a sharp drop in the number of consultants entering the health service with any experience of undertaking research and that augers poorly for the future of health services research, in particular clinical trials, where you need to have a consultant with some insight into the research process. Unless the young people coming through in their clinical training have some experience of research the whole research base in this country on health service is going to collapse.

Lord Butterfield

1149. In England it is proving difficult to sustain the patient flows required for research. This is because tertiary consultation potentially costs money, and we have evidence of people doing very good research for whom the number of patients for investigation and development of new techniques has dried up. Are you getting the same kind of problem in Scotland or is this an English disease?

(*Professor Bouchier*) At the moment it does not effect us in Scotland. I suspect partly because Scotland is behind England in the implementation of changes in practice and that has an effect.

1150. You have not run into it?

(*Professor Bouchier*) No.

1151. Separate funnels have got to be set aside in the overall research budget to pay for these. I do not think they would be a very significant part of the overall research budget. It would be the cost of putting a patient in hospital for a period or it might involve special techniques, imaging or whatever; we

do not know how to do deal with it at the moment. If the manager says to the doctor who wants to send the patient, "We really cannot afford that in the budget this year so that must not happen," or if the manager of the hospital that has the research unit says, "I am sorry but I do not want to add any more costs to support your research," again it is an awkward blockage where management is taking precedence over the possibility of conducting research, which worries us of course.

(*Professor Bouchier*) We fully see the problem and we have spoken about it. All I can repeat is that we have not encountered it in Scotland yet.

1152. Probably your managers understand research well. Do you have the hope and intention of increasing ACT and do you hope to see the single stream for research funding disaggregated from ACT for the future?

(*Dr Kendall*) I think, my Lord, that it is probably inevitable that it will be disaggregated.

1153. If it is, and let us suppose that the research component is notionally 25 per cent, you say it may be much more—

(*Dr Kendall*) It is 25 per cent. £94 million is the basic ACT cake.

Chairman

1154. The suggestion of the Royal Society here is that it should be distributed through the Chief Scientist Office and administered at a local level by collaboration between the medical school dean, teaching hospital trust management and the health board treasurer. Would this system be an improvement on the present arrangements?

(*Dr Kendall*) One of the things we have to think about is the funding of research in primary care and some of that will be remote from under-graduate deans. Some of problems we are already aware of in the funding of Medical Research Council trials are studies based in general practice where fund holding GP's in particular say, "I cannot afford to put my patients into that study unless somebody is going to give me extra money." I think we must find a mechanism whereby some of that money goes into primary care, or is available to provide the infrastructural costs of research in primary care, and it is not obvious to me that under-graduate deans are the best people to be in control of that.

1155. Let us take a potential model for England, not Scotland, whereby the R stream is identified from SIFTR. A substantial component of that is at the disposal of Michael Peckham and his group for prioritised national programmes of research which may involve the establishment of research units and so on wherever in the country; a second component is delegated down to a regional director of R&D where an appropriate committee is able to spend some of that money on locally operated clinical research, some of it on locally operated health services research and some of it on general practice in the community; whereas a third stream would go into what at present is like the R component of ACT for the support of infrastructure and facilities research

28 February 1995]

DR R E KENDELL AND PROFESSOR I A D BOUCHIER

[Continued]

[Chairman *contd.*]

according to an assessment exercise. Is this a tripartite mechanism you could see as fulfilling those objectives?

(*Professor Bouchier*) One of the difficulties is that Scotland is so small that to break it down quite like that may not be appropriate. For example, the total population of Scotland is much below one of the newer regional health authorities so we could not do quite the same mechanism. There is no reason why the streams might not be identified, that is fair, but the actual administration of the spends and monitoring may have to be done differently just because of the size of Scotland.

1156. You could have two streams, one from your Office and the other would go to the under-graduate deans and health boards etcetera as proposed.

(*Professor Bouchier*) Yes, as long as in the end the spend is monitored and it is accepted that it falls within national priorities. There should be a place for curiosity-driven research, as long as there is some monitoring system that goes on.

1157. Have you any additional points that you would like to raise with us?

(*Professor Bouchier*) No, my Lord.

Lord Perry of Walton

1158. I should be grateful if you could send us a note of what these sums in ACT are.

(*Dr Kendell*) Very gladly.

Chairman

1159. Because we gather the formula in Scotland includes whole time post-graduate students as well as under-graduate students.

(*Dr Kendell*) It certainly did at one stage and I suspect that is erroneous. That may be the historical reason that ACT is about 15 per cent higher per student in Scotland.

1160. Quite. So you do not think it does now? It only takes into account under-graduate students?

(*Dr Kendell*) I think it is under-graduate students. That is why if you divide the sum by the number of clinical under-graduate students it comes to £42,000, and that is in broad terms 15 per cent higher than the corresponding figure in England.

Chairman] All the more reason why we look forward to having the paper from you that Lord Perry has requested. Thank you very much.

Additional note from the Royal Society of Edinburgh

1. NHS R&D Strategy

The NHS R&D Strategy for Scotland since 1993 appears to be strongly preoccupied with the mechanism of delivery of R&D rather than with encouraging R&D itself. As stated elsewhere in the Royal Society of Edinburgh's responses, Fellows of the Royal Society are very concerned that any changes in funding and facilitating of medical research in Scotland does not in any way compromise basic scientific research. The change in emphasis of the Biomedical Research Committee to the Acute Healthcare Committee, and its stated policy of only funding projects which will have a **direct impact on diagnosis or therapy within the lifetime of an award** is considered by many to be very restrictive. The bulk of the Chief Scientist's Office awards are for two years only, and members of the Enquiry Committee will appreciate how rarely it is that such projects can have clinical implementations within the lifetime of the award.

A further area of concern is an apparent policy decision made by the Chief Scientist's Office **not to fund any developments in molecular genetics** on the basis that earmarked funding is available for these through the human genome project. In fact many of the more clinically related genetics projects would not obviously be funded through the human genome project, and at present therefore this important fruitful area of research is falling somewhat between two stools.

It is of some concern to scientific and medical academics in Scotland that the emphasis on basic biomedical research appears to be very much less than previously. This is in contrast with what appears to have happened South of the Border where Professor Michael Peckham has devolved individual R&D budgets to regions—for example the North East region based in Newcastle is responsible for R&D in cardiovascular disease and that in Bristol for cancer related projects. In addition to this devolution, Professor Peckham's groups are encouraging longer term national projects and have placed *less* emphasis than in Scotland on the immediate application of the results of biomedical research. Members of the Committee will appreciate that in many situations it takes perhaps five to seven years for the clinical implications of important research to be recognised and actioned. It is our view that a two-year timeframe is too short, and may prevent funding of a lot of projects whose medium term results would be very beneficial to the NHS and the patients.

As stated in paragraph 2 of our memorandum on Scottish structure there are no individual directors of research in the Health Board areas or regional equivalents. An early impression of the new situation in England and Wales is that this is advantageous to the biomedical community and to the facilitating of research projects. Many of those working in Scotland would like to see consideration given to more local activity and the appointment of regional director equivalents for R&D.

28 February 1995]

[Continued]

2. *The Culyer Report*

Our statement that we welcome the suggestion that the terms in which NHS provides service support to external funding bodies should be reviewed is because of the fact that there have been varying responses of new trusts in their commitment to research. A local example of this has been the competitive award of an MRC clinical research initiative in cardiovascular research to the University of Glasgow and the West Glasgow Hospitals NHS Trust. This was a hard won initiative, and the topic is obviously very relevant to the Scottish population at the present time. The negotiations between the University and the newly formed Trust in terms of an appropriate contribution towards space and other matters have been disappointingly lengthy, and there has been an impression that the Trust was loath to make a significant commitment to this important enterprise. Clearer definition of a trust's responsibility to this situation would have been advantageous.

3. *Research and the Internal Market*

Evidence that there are problems with clinical trials because of the new NHS structure is clearly given in the UKCCCR publication in the *British Medical Journal* of 13 August 1994. Professor John Smythe, Department of Clinical Oncology at the University of Edinburgh is lead author on this paper, which illustrates very clearly the problem of attracting adequate numbers of patients for cancer trials. It states that 50 per cent of those involved in cancer clinical trials are experiencing problems in terms of lack of time and staff availability.

In the past two years a Scottish Cancer Therapy Network has been developed which facilitates collaboration in clinical trials between the major Scottish centres (Edinburgh, Glasgow, Dundee and Aberdeen). The support is mainly in part-time secretarial staff, and it is too early yet to assess whether or not this network will help to alleviate the current problems experienced by those trying to establish or maintain good cancer related clinical trials.

4. *Joint planning of hospital reorganisation in Edinburgh*

This question should be answered by Professor Edwards directly. At present a similar exercise is being carried out in Glasgow in that the Acute Strategy Review recently published for public consultation by Greater Glasgow Health Board proposes a reduction in the number of beds available in GGHB and suggests a closure of clinical beds on the Western site which is immediately adjacent to the main University Campus and basic science departments. It is proposed that all patient related activities currently taking place on the Western site will be relocated some two miles west at Gartnavel General Hospital. It is not yet clear whether or not this will be the outcome, and intensive negotiations are currently in progress between officers of the University and the Health Board to try to ensure the optimum solution for patient care, undergraduate and postgraduate teaching and clinically related research. There is at present considerable concern amongst the clinical academic community that geographic separation from basic scientists with whom they work closely (eg Professor Miles Houslay, Department of Biochemistry, and Professor Janet Allan, Molecular Medicine) would be deleterious to ongoing curiosity driven research.

5. *Career Path for Clinical Academics*

This is most certainly a problem in Scotland as well as England. The reduction in registrars in Scotland means that those who are currently in post have extremely heavy rotas, and the traditional one to one and a half days a week available for clinical investigation and research is no longer available. This will be to the detriment of the trainees who in the past could use this time to work towards an MD, and also to the future academic community. A brief exposure to clinical research by those in training who plan to go on to an NHS career tends to ensure that even if these individuals do not stay in research related posts they have some understanding of and sympathy for the problems of the academic community. The divide between NHS paid clinicians and university paid clinical academics is becoming much wider than it has been in the past, and it is the Society's view that this is likely to be deleterious to both parties.

The recently published Winyard Report on implementing the new unified training requirements suggests that while the training period for many specialties will be four years, time out for research will be allowed. It is important to establish whether or not this time out will be funded by the NHS or whether individuals who wish to take this time out will have to acquire their own funding from competitive research grants. If the latter is the case, the possibility of a low uptake and consequently a more narrow career training for junior clinical staff would be an unfortunate outcome.

Another important point to emphasise is the relatively poor image of a clinical academic career both in Scotland and in other parts of England and Wales. In the past a clinical academic career has been regarded as one which allowed the more intellectually gifted students and young postgraduates to exercise their skills. At present the volume of paperwork and administration which is being required of senior academics creates an image of clinical academic activity which is not desirable. It is important to try to redress this balance so that a clinical academic career appears to have some intellectual advantages.

*28 February 1995]**[Continued]*

In addition there are financial problems associated with the greater likely financial benefits of an NHS career particularly for those who work in surgical specialities, and the number of candidates for academic senior posts in for example ophthalmology, orthopaedics and cardiac surgery are low. In addition to low numbers, it is often the case that the quality of the applicants is perhaps less than might be desired. This is a worrying situation.

7. Research beds

To the knowledge of the Fellows of the Royal Society there are no designated research beds in Scotland.

Additional memorandum from the Scottish Office Home and Health Department

Additional Cost of Teaching (ACT)

1. The Additional Cost of Teaching (ACT) is the element in Health Boards' revenue allocations designed to provide the NHS support for clinical teaching and research. ACT is the equivalent of SIFTR (Service Increment for Teaching and Research) in England but ACT is the only stream of funding for the NHS support of research.

2. ACT is related to the average differences in the level of costs of teaching hospitals from that of district general hospitals. In 1994-95 ACT funding represented £42,362 per clinical medical student (about 15 per cent higher than the level of SIFTR) and amounted to a total of £93.87m. It is distributed to the four teaching Health Boards in proportion to student numbers. Where some teaching of undergraduate students is carried out in non-teaching hospitals, an element of ACT is paid, commonly at a much lower rate per student year; in principle the money follows the student. There is no component in ACT for postgraduate teaching or research though postgraduate students have been included in the student number figures used in the central allocation of ACT monies. There is at present no arrangement for the notional research element of ACT to flow into non-teaching Health Boards, or to the primary or community care sectors.

3. Health Boards are expected to provide funding for academic departments of general practice from ACT. This amounts to £1,020 per student in the final clinical year. The total cost in 1994-95 will be £622,000. Dental hospitals receive a lump sum which is revalued each year. In 1994-95 this amounts to £10.85m.

4. SIFTR is only one element of NHS support for teaching and research in England. The proportion of 25 per cent which has been estimated to be the research element of SIFTR is unlikely to read across to the element of ACT which relates to research in Scotland. The Scottish Office has not yet attempted to estimate the R element of ACT.

Clerk's summary

5. In the table on page 1 of the summary, ACT is shown as contributing £30m to research funding in Scotland in 1992-93. As noted in paragraph 4 above, the research element of ACT has not been estimated and it would not be valid to assume that the estimated 25 per cent research element of SIFTR, applies to ACT. It probably lies somewhere above 25 per cent. It is also the case that the research component of ACT is for the support of research: it does not fund research directly. It is suggested therefore that the contribution of £30m from ACT be deleted from the table in favour of a footnote which might take the following line: "In Scotland ACT (the Additional Cost of Teaching) which is equivalent to SIFTR in England, provides the NHS support for clinical teaching and research. ACT amounted to £9.3m in 1992-93. The element of research support is not separately identifiable".

The Project Register System in Scotland

6. It is possible that the Committee may have gained an erroneous picture of the operation of the Project Register System in Scotland and this memorandum sets out the position for the avoidance of doubt.

7. At present the Chief Scientist Office publishes an annual Health Service Research Register. This aims to provide a ready source of information on health service research studies which are underway or have recently been completed. The Register includes studies supported by the Chief Scientist Organisation, studies supported by other organisations such as research agencies and Health Boards, and personal projects being carried out for the purpose of professional training or development. Contributions to the register are entirely dependent on voluntary notification. The Register for 1994 is due to be published shortly.

8. As part of its information system strategy, the Department of Health set up the Project Register System (PRS) in 1994 to assemble information on current health research in a database to which all major UK funders would be asked to contribute data. The Chief Scientist Office contributes financially to the costs of the PRS centre and expects to provide data on its funded research projects during 1995. In addition, the Office is developing arrangements to capture data from all other health research funders in Scotland to contribute

*28 February 1995]**[Continued]*

to the PRS database. CSO now hold a copy of the database and, in concert with arrangements for the collection of Scottish data, we will be developing proposals for disseminating the PRS database to interested parties in Scotland.

9. Much of this work links in very closely with the dissemination of results from the UK Cochrane Centre and the NHS Centre for Reviews and Dissemination both of which CSO co-fund. Also CSO are in the process of appointing an Information Manager to lead the important work of disseminating research results in Scotland.

Consultation on priorities

10. Having established the national priorities for R&D in 1993 the Chief Scientist Office was anxious to establish if they required any refinements to meet more local R&D needs. We asked Health Boards, Trusts, Universities and a wide range of professional and health organisations to set out their six top priorities for both research and development.

11. Around 100 responses were received. After attaching weighting to the submissions eg to reflect the importance of Health Boards as purchasers, the analysis of the responses showed a strong measure of support for most of the established national priorities for both R and D. Perhaps understandably, local interests did not attach a strong priority to research or development into AIDS, clinical application or drug and substance misuse. There was a large measure of support for R&D within the priorities relating to primary care, and community care. These are areas which CSO is already seeking to encourage under the strategy. The only topic to be sufficiently identified as a specific new priority subject was telemedicine.

12. The exercise was valuable in confirming the appropriateness of the national priorities at the local level and the results will help to inform the detailed implementation of the strategy.

Small grants

13. SHERT's Corporate Plan aims to concentrate their support in this area but CSO will also continue to support low cost opportunistic or feasibility studies through its programmes. The CSO mini-grants scheme is particularly designed to fund research projects up to £10,000.

Research beds

14. There is no centrally held information on this subject but a number of research funds are known to support research beds to some extent although these are not necessarily held available exclusively for research patients.

Urban reorganisation and joint planning

15. The joint planning process referred to by Professor Edwards has been evidenced in a number of ways. There is, first of all, an overarching machinery consisting of regular meetings between Scottish Office officials (representing Health Policy, NHS Management Executive and Education Department interests) and the Principals and Deans of the Scottish Universities with Medical Schools. In addition the Chief Medical Officer meets the Deans of the Faculties of Medicine twice-yearly.

16. In relation to the development of the Lothian Acute Services Strategy, care was taken to ensure that the University's interests were taken fully into account in Lothian Health Board's planning. The meetings that took place between the Board and the Management Executive were generally also attended by Professor Edwards. Following ministerial approval of the acute services strategy last November the Royal Infirmary of Edinburgh Trust and the University have been collaborating closely in defining their joint requirements for the new hospital which is to be built in South East Edinburgh. Similar liaison is in hand in relation to the planned developments at the Western General Hospital which flow from the acute services strategy. Meanwhile, discussions are taking place within the Scottish Office at official level to clarify issues relating to the funding of those developments of the University's medical school which are consequent on the acute services strategy.

17. Other features of the Scottish scene have been relevant. Scotland's small size frequently makes collaboration between different agencies—and between Government and agencies—easier to achieve than is always the case elsewhere. As far as the Lothian acute services strategy is concerned it has been a distinct advantage that the key players are well known to each other. We also benefit in Scotland from the integration of several departments—in this case Home and Health and Education—within a single department of state under one Secretary of State.

*28 February 1995]**[Continued*

18. The specific characteristics of Edinburgh's NHS and University scene (and the structure and workings of the Scottish Office) might not be directly relevant to other cities in the UK. It would also be fair to point out that the Lothian acute services strategy is still at an early stage of implementation. Nonetheless, experience so far would attest to the importance of regular contact between the relevant agencies, at various levels and in both formal and informal contexts, and of the close involvement of government.

21 March 1995

TUESDAY 7 MARCH 1995

Present:

Butterfield, L.	Perry of Southwark, B.
Flowers, L.	Perry of Walton, L.
Gregson, L.	Selborne, E.
McFarlane of Llandaff, B.	Walton of Detchant, L.
Nathan, L.	(Chairman)

Memorandum by the Association of Young Medical Scientists**INTRODUCTION**

We thank the Committee for the opportunity to discuss the implications of the health service reforms on medical research and hope that we may be able to provide a perspective from both junior academics following a career in medical research, and those involved in a period of research training as part of general and specialist medical training. I hope it will be helpful to the Committee to briefly outline the role of the Association of Young Medical Scientists (AYMS) since it was set up just under two years ago.

Following a suggestion from the Academic Medicine Group at the Royal College of Physicians, career research fellows were invited to form a group within the Medical Research Society (MRS). Under the initial direction of Professor Morris Brown, senior research fellows from the major research charities were asked to form the initial group. Since that time and following the formation of a committee to direct the activities of AYMS as it became known, we have attempted to maintain a database of research fellows, both clinical and non-clinical, whom we and others can contact when soliciting views and opinions on relevant matters. The group have also been able to submit work to the MRS biannual meetings which also include the annual Science and Medicine Conference at the Royal College of Physicians. The aim of this has been to present the highest standard of research work in the widest possible audience including those still contemplating a career in academic medicine for whom meetings with a broad research base are especially important.

Apart from this present meeting, we have also been fortunate to have had constructive dialogue with The Royal College of Physicians, the NHS Management Executive, the Medical Research Council and the Chief Medical Officer.

It would also be fair to say that after less than two years we are still in the process of expanding our database and trying to bring ourselves to the attention of the academic community as a whole. With regard to being fully representative, at present we have made formal approaches to the medical research community via organisations such as the MRC, the Wellcome Trust, the British Heart Foundation and the National Kidney Research Fund, who with other research councils and members of the Association of Medical Research Charities, fund the majority of the research fellowships. Therefore specialties such as surgery and obstetrics and gynaecology are very under represented. This is an area that we would obviously like to address.

I would like to briefly highlight the following areas which may be suitable as discussion points with the Committee. These have either been the subject of frequent debate at Association meetings, are areas brought to our attention by individual members, or are issues that have been specifically highlighted for discussion at this meeting. Although some of these issues may not directly be considered as part of the NHS reforms they have been included as the impact of these changes are likely to be far reaching and extend into many areas of the research community.

(1) CAREERS IN ACADEMIC MEDICINE

By far the greatest concern has been expressed over the future of careers in academic medicine and the effects of the new unified training grade, the failure of the expansion in consultant numbers, the reduction in the number of clinical academic posts, and the increasing demands that the NHS reforms have had on both clinical and non-clinical activities to the detriment of protected research time.

(1.1) *The New Unified Training Grade*

Whilst fully supporting the establishment of a shorter and more structured training grade it has been recognised that these changes could have a significant adverse effect on research training. Points of concern include a failure to recognise that research training cannot simply be added on to a clinical training, but is part of a training that leads to a different role and career structure. The focus on a strict timetable and content of clinical training could lead to a position analogous to that currently experienced in the surgical specialties. The unified training grade should also take into account the fact that research training is not necessary or required for all clinicians and that poor quality research can have detrimental effects on future perceptions

7 March 1995]

[Continued

of the research community. Thus great flexibility will need to be retained in the new system to facilitate and increase the numbers in academic training.

(1.2) *Career opportunities for Senior Researchers*

The expanding numbers of research training fellowships, clinician scientist fellowships, and clinical senior fellowships makes it imperative that consideration be given to the establishment of appropriate numbers of senior positions. The failure of expansion at this level will generate a cohort of highly trained clinical researchers who are unsuitable for purely service posts with the resultant waste of years of training. The recognition of two distinct career tracks will underpin the success of UK medical research. Senior academic posts should also have built in to them sufficient protected research time. This would also have to be monitored at a local level so that undue pressures cannot be exerted which reduce this time. The effects of this would only be seen in the long term with a reduction in the research productivity of a unit for the sake of short term service gains.

(2) THE SCOPE OF MEDICAL RESEARCH

Much has been discussed regarding the establishment of research programmes with defined health service implications as their driving force. Concern has been voiced that basic science research often with long term aims may be "side-lined" in these circumstances. This can obviously be prevented by non NHS funded work but careful, independent assessment of current and new projects would be desirable to maintain the correct balance.

The spectrum of clinical research also depends on continued access to the patients that stimulate it. This may be the single patient whose condition provides important insights in to a whole area of cellular or organ function or large groups of patients whose combined characteristics help to define a disease or clinical response. It is clearly vital that such patients may still be freely referred to research centres without financial penalty. This also implies that research centres of excellence are also clinical and service centres of excellence and emphasis on the latter must be maintained. Research driven costs are likely to exceed purely service driven costs for this group of patients and therefore mechanisms should be in place to allow this without bringing "the Academic" and "the Trust" in to conflict. One possibility is that the R component of SIFTR should be specifically directed towards this role especially for units of proven excellence, and also to underpin other overhead costs of hospital based research.

The research/hospital interface is also under threat from fragmentation of hospital services. Thus any plans to alter the provision of services, such as changing hospital sites, and the closure of units, must be sensitive to the needs of research departments. This implies that there needs to be a fundamental rethink in the way research is viewed by health service administrators and planners.

I hope that I have been able to condense the points that have been put to me for discussion and that they may provide the basis for dialogue during our meeting with the Select Committee. Hopefully we may be able to enter other areas of discussion that have not been specifically mentioned in this letter. We also hope that AYMS may be considered a useful point of contact for further discussions in the future. Perhaps we may be able to keep you informed of our progress.

Dr Richard Sandford PhD MRCP

24 February 1995

Examination of witnesses

DR RICHARD SANDFORD, MRC Clinician Scientist, Hon. SR in Clinical Genetics, DR PETER MATHIESON, MRC Clinician Scientist, Hon. SR in Nephrology and DR KRISH CHATTERJEE, Wellcome Senior Fellow, Hon. Consultant in Endocrinology, members of the Association of Young Medical Scientists, were called in and examined.

Chairman

1161. Dr Sandford, Dr Mathieson, Dr Chatterjee, thank you so much for agreeing to come and talk to us. I wonder if you would be kind enough to introduce yourselves, tell us what you are doing and where and describe your career paths as you see them indicating whether they are typical or exceptional.

(Dr Sandford) My Lord Chairman, if I may start. My name is Dr Sandford. I am currently a Medical Research Council clinician scientist. I work in the Department of Medicine in Cambridge specifically

between two departments, Clinical Genetics and the Department of Medicine. I work in the basic science department of molecular genetics which is in fact run by Dr Sidney Brenner. I am obviously a medical graduate and I have just been through fairly straight forward general medical training, initially in the Leicester Group of Hospitals and then at the Hammersmith Hospital in London before embarking on a Medical Research Council training fellowship also held in Cambridge for a period of three years which led on to a PhD and then subsequently taking up the clinician scientist fellowship straight after that.

7 March 1995]

DR RICHARD SANDFORD, DR PETER MATHIESON
AND DR KRISH CHATTERJEE

[Continued]

[Chairman *contd.*]

1162. Thank you. Dr Mathieson?

(*Dr Mathieson*) Yes, I am Peter Mathieson. I am also currently an MRC clinician scientist fellow having started my fellowship a couple of years ahead of Dick Sandford. I trained in medicine in London and did junior hospital jobs in and around London and then went to Cambridge as an MRC training fellow to do a PhD in cellular immunology. I finished that in 1991 and then immediately started the clinician scientist fellowship which I am now coming towards the end of. Your question about whether these career paths are typical or exceptional is already being answered by the fact that Dick Sandford's and mine are rather similar and I think you will find that there are similarities between the three of us in our background and our paths therefore might not be considered particularly exceptional. As compared to the broader gambit of medical graduates I think it is rather exceptional in that all of us have taken periods of doing basic research completely divorced from clinical practice.

1163. Thank you. Dr Chatterjee?

(*Dr Chatterjee*) Yes. My name is Krish Chatterjee. I am an endocrinologist also based in the Department of Medicine in Cambridge. I first trained in Oxford and I completed my general medical training at the Hammersmith Hospital in London. Perhaps one way in which my career path is slightly different from what you have heard already is that I chose to spend the initial part of my research training in the United States. I went to the Massachusetts General Hospital in Boston on an MRC Travelling Fellowship in 1987 and stayed out there on NIH funding thereafter. In 1990 I decided to return to the United Kingdom, to the Department of Medicine in Cambridge as a Wellcome Senior Clinical Research Fellow and that is where I have been since.

1164. Of course, you all come, therefore, from one centre. Could you tell us in your Association how many members you have and how widely they are spread geographically throughout the major centres in the United Kingdom?

(*Dr Sandford*) My Lord Chairman, if I may answer that question. Currently we have approaching nearly 200 people, whose names are maintained on a database which we employ as a mailing list. Initially we gathered those names by approaching the major funding charities and funding councils, specifically the Wellcome Trust and Medical Research Council and a few other groups. So really what we are currently representative of is the cohort of people that are funded by those groups. So in a sense we are not particularly representative and we do tend to reflect the distribution of their funding so perhaps we do have a majority of people who come from the larger research centres such as Oxford, Cambridge and a lot of the London centres. We are managing now, over the last two years, to attract other people from the other larger centres throughout the United Kingdom. We are becoming more representative but I must also point out that also we tend to represent those people who are following a medical as opposed to a surgical research path, for example.

1165. Your document makes it clear that you feel that your Association is under represented in fields

such as surgery, obstetrics and gynaecology and one or two other disciplines.

(*Dr Sandford*) Yes.

1166. Do you include within your membership any individuals with tenured posts or are you all individuals who hold comparable posts to the Wellcome Senior Research Fellowships or the MRC Clinical Scientists? Are you mostly honorary senior registrars?

(*Dr Sandford*) That would be a very typical cohort of people in our particular group, yes, although we are trying to expand out further. I think the very nature of the way that we initially approached people meant that we were likely to select people who were in very similar positions to ourselves. That was a positive point of forming the group.

(*Dr Mathieson*) There is no stated aim to exclude people with tenured posts or people of consultant status either. I think the intention was that these were people at all stages of academic career paths.

1167. Yes, though Dr Chatterjee is an honorary consultant?

(*Dr Mathieson*) Indeed, yes.

(*Dr Chatterjee*) But only recently.

1168. Then can I ask you how much of your time are you able, within the appointments that you hold, to devote to clinical work as distinct from clinical or laboratory research?

(*Dr Sandford*) My Lord Chairman, again if I may start, my particular clinical speciality now is clinical genetics. I have recently changed from clinical nephrology to genetics. At the moment I am currently trying to maintain a balance whereby my clinical commitments form probably only about a fifth, 20 per cent, of my total time spent at work.

1169. Is this typical?

(*Dr Chatterjee*) Yes, I think so. For example, my clinical commitment at present is about two outpatient sessions, per week and then approximately two months of the year doing general medicine on the wards, somewhat along the American lines.

1170. Is it your impression that your clinical research activities are understood and valued by the hospitals in which you work and can you give us some examples?

(*Dr Mathieson*) We thought that was an interesting question in that we were not certain who was doing the valuing and understanding. Generically we felt that the answer was that we did feel valued and understood in that the institution certainly that we work in, and our experience from talking to other people, is that the environment allows us to do clinical research and pursue academic careers. Understanding and value is certainly present if it is not translated into money and resources where sometimes there is a feeling that institutions will value this sort of activity as long as they do not have to pay for it themselves. In terms of a specific example, one thing that occurred to me is that when I first started in Cambridge I was involved in the treatment of a patient with difficult auto-immune disease with an entirely experimental therapy using a genetically engineered antibody. It made a very

7 March 1995]

DR RICHARD SANDFORD, DR PETER MATHIESON
AND DR KRISH CHATTERJEE

[Continued]

[Chairman *contd.*]

lasting impression on me the degree of interest shown by the basic scientist who had been involved in the very early stages of the development of this antibody in its clinical application. I felt privileged to be at the end of that process, applying years of basic science to a clinical use. I was very struck by how the basic scientists were tremendously grateful to us for going back and telling them how successful it had been and seeing an application of all their work. That was something which encouraged me to think that however distant the clinical applications may seem in basic science research ultimately it may be something of great value to the basic scientists in their laboratories.

1171. Do you feel that those who are on the standard NHS ladder as registrars and senior registrars or those who are working, say, as lecturers in university departments and with whom you are associating regard you as part of the clinical community or are you a breed apart?

(*Dr Mathieson*) I think they regard us as part of the clinical community although there are caveats. I think there is a feeling amongst our peers and our seniors that we have to prove in some way that we are clinically capable and as good as the next person who has not spent a lot of time in the laboratory. That is something that we do feel that we have to constantly reassert although I think all of us would be very happy to be judged on those grounds.

Baroness McFarlane of Llandaff

1172. You have already talked about the proportion of your time that you spend in clinical work, we wondered how easy it is for young clinical academics to satisfy their service, teaching and administrative commitments as well as making progress in research?

(*Dr Mathieson*) Perhaps I could answer that, in that I did not really answer the previous question about the question of time. My clinical speciality is nephrology, renal disease, and it illustrates some inter-speciality variation in the answer to that particular question. Nephrology tends to be a busy clinical speciality with a heavy in-patient load and patients who are often very unwell. It has been quite difficult to organise a training scheme which is acceptable both to me in terms of providing suitable experience and to those people judging my training to prove that I have satisfied those requirements to find a balance between spending time in the laboratory and time on the wards. The way in which I have resolved that is by spending the first three years of my clinician science fellowship entirely in the laboratory and now more or less accepting that I am not doing any laboratory work and spending full time currently working in the hospital. That is rather unsatisfactory if you do it that way round. It means that the research inevitably enters a period of lack of productivity.

(*Dr Chatterjee*) If I could follow on. One other point relating to my experience in training was the difficulty that I had in persuading people that one could undertake training in a dovetailed fashion. Endocrinology and Diabetes is largely an out-patient driven speciality and we therefore argued that much

of our experience could be accumulated by doing one or two clinics per week. Yet, at the end of the day, it was still felt that despite having accumulated a number of years of that type of experience, we still had to take a substantial amount of time out of the laboratory in full-time clinical work which was disruptive. I think that was one of the difficulties that we encountered.

Lord Butterfield

1173. I wonder if you can try to interpret the views of your other members in answering this question of the opportunities that there are in terms of time or resources for young medical scientists to conduct curiosity driven clinical research as distinct from health services research? Obviously you are all pretty close to curiosity driven research but is that a general finding among young medical scientists?

(*Dr Sandford*) No, I think in a sense perhaps we are a little bit atypical or exceptional because the very nature of the fellowships that we hold in terms of actual numbers, for example the clinician scientist fellowship in the Medical Research Council will be awarded to between eight and ten people per year, we are a very small cohort of people.

1174. Yes.

(*Dr Sandford*) In terms of what opportunities in time or resources we would initially suggest, certainly the level of training fellowships of what is currently undertaken immediately post-registrar training, one would suggest probably fairly ample opportunities if one actually looks through from the research councils and the Association of Medical Research Charities to what training fellowships are currently available on a competitive basis. That obviously highlights a certain proportion of medical research but we understand that a lot of other medical research is performed by people who are funded not from within these organisations but perhaps by soft money, pharmaceutical money, and who may have necessarily to combine that with some service commitment. It is a very, very broad spectrum here. I think one end of the spectrum people will struggle while having to maintain a clinical component and also generate some research data and perhaps that may be highlighted a little bit by how surgery has developed as a research speciality when there is a major element of service and training as opposed to research as compared, as you say, with more curiosity driven clinical research which perhaps we represent where we have found no hinderance to pursuing that line.

1175. Do you think the young surgeons have any time for curiosity driven research?

(*Dr Sandford*) My remarks are obviously based on the general observations of people I have spoken to because we have had a number of people approach our particular group who are in surgical specialities, including obstetrics and gynaecology. The very real complaint is that they are so driven by the surgical training aspect that they have to fulfil a requirement to perform a certain number of procedures that whatever research they undertake invariably forms a very small part of their time or is pursued out of hours or at weekends. I think there is a very different

7 March 1995]

DR RICHARD SANDFORD, DR PETER MATHIESON
AND DR KRISH CHATTERJEE

[Continued]

[Lord Butterfield *contd.*]

split and it very much depends on the nature of research.

(*Dr Mathieson*) My Lord Chairman, I wonder if I could add a point about the institution, in that the opportunities for research are dependent upon constraints of careers and training but also on the institution. I think perhaps we have all been privileged in working in institutions which have afforded us those opportunities. One wonders whether people working outside the major centres have the same opportunities.

Chairman

1176. Has there been any evidence to date from your members that the pressures of the internal market in the NHS have in any way restricted your opportunities for engaging in clinical research?

(*Dr Chatterjee*) Yes. There is a specific example that I can highlight in terms of conducting clinical research within the NHS which relates to the disease that I have a particular interest in. We are studying a rare thyroid disorder, the genetic basis of which has been recently elucidated. We are now in the fortunate position of having accumulated the largest cohort of families with this condition worldwide. So three or four years ago I tried to embark on studying the clinical features of the disease in this group of patients. Whereas in the past it would have been relatively easy to talk to my colleagues and get the patients to come to a central centre for assessment, with the changes that have taken place this has proved much more difficult. In general this is not a debilitating illness and making the cases extra contractual referrals would not really have therefore been justifiable. It meant that we had to seek alternative sources of funding to cover the costs of accommodating the patients and doing the research in Cambridge. Four years ago, there was simply no mechanism whereby one could do this. At the end of the day the obstacles did not prove completely insurmountable. This was due to the fact that when I approached the Wellcome Trust and asked them, for example, to provide a bit of funding to cover bed and breakfast accommodation for the patients next to the hospital or to pay their subsistence in the hospital cafeteria, the request slightly to my surprise was not laughed out of court completely. Nevertheless I think it is fair to say that it has imposed a constraint and curtailed my ability to undertake very sophisticated forms of research in this group of patients. It has meant that we have been restricted to doing very, very simple studies.

Lord Flowers

1177. Is it possible for you to say how commonplace that state of affairs is?

(*Dr Chatterjee*) I would think it is becoming increasingly common place because, as I say, when I came back in 1990 the reforms had taken place and it was immediately apparent that this was a problem. There was simply no mechanism.

Chairman

1178. If funding could be obtained either from external or NHS sources to fund research out-patient sessions or even a very limited number of research beds this might be a possible way of handling this difficulty?

(*Dr Chatterjee*) Yes, I do not see any difficulty with applying for that sort of funding. It is simply, as I say, that at present there is no mechanism for doing so.

Lord Perry of Walton

1179. Could I ask you what your main reason for going into this was? What drove you into this rather than into pure clinical medicine?

(*Dr Mathieson*) If I start by answering that question. I think to some extent again it rests on opportunity and advice that one receives at a fairly early stage in clinical training and that depends fairly heavily on the institution in which one is working at the time and also on people providing the advice. It was an opportunity, certainly as far as I was concerned, to apply my medical training to answering a scientific question and for being given the opportunity to pursue it at some length. I think that was a very attractive application of a medical degree. Personally I do not think there was any conscious stage where I suddenly decided this was what I was going to do. It happened by a process over a period of time where I did some research, enjoyed it and there were ups and downs but generally it went reasonably well and there was encouragement to continue both personally and also from people around me.

1180. Do you agree with Professor Harris, who told us in November (Q170) that money does not come into it?

(*Dr Mathieson*) Wholeheartedly yes. Professor Harris was talking about the disincentives I think more than about the incentives really. The incentives perhaps are rather nebulous and we all find ourselves doing it and then we start becoming concerned about the disincentives.

1181. In your paper in 1.2 you make the point "...that consideration be given to the establishment of appropriate numbers of senior positions." To what did you refer, senior lectureships and professorships in university?

(*Dr Mathieson*) Yes, one thing that all of us are concerned about is the perception that the career path of clinical academics is less clear and less clearly marked out than the career path for hospital physicians or indeed general practitioners.

1182. As far as I can tell from the figures there are more senior jobs available in universities per trainee than there are in the health service.

(*Dr Mathieson*) That may reflect the numbers of trainees I suppose but yes I think it is a problem of perception really. I think the reality actually may be not as bad as we all feel in our moments of insecurity. It is just that by leaving clinical practice and going off and doing research, which inherently if it is to have any value contains an element of risk, it is the feeling that we are doing that, and all we are after really is an

7 March 1995]

DR RICHARD SANDFORD, DR PETER MATHIESON
AND DR KRISH CHATTERJEE

[Continued]

[Lord Perry of Walton *contd.*]

opportunity to perceive some sort of post that is likely to be suitable for us at the end of the day.

1183. Is that risk going to be magnified by the introduction of the numbered specialist registrar grade?

(*Dr Mathieson*) Potentially yes.

Lord Gregson

1184. I am an engineer so I only think logically. It worries me a great deal, looking at this medical research problem, that there is no clear logical structure to the whole thing which is what you are saying at the moment. It was a professor at MIT who said that unless you do your original thinking before the age of 21 you might as well give up. It seems to me that the length of training and the additional qualifications you need to establish a fellowship, you really come into the research situation somewhat older than most people. Does that worry you at all?

(*Dr Sandford*) No, I do not think it does worry us in a sense. Everybody who goes through clinical training will at least at one time consider a period of research training. It is fairly clear for a lot of people who end up in an academic career that this is what they are going to pursue, whether they decide before research or just having started it. I think it is one thing that most people will be very accepting of. Obviously to fulfil a clinical training and a science training there is going to be a time penalty—if you want to call it a time penalty—as such. People are very accepting of that but what it must never be made into is an unacceptable time penalty.

1185. The other thing that worries me about the mould that you people have, you are successful in your training and qualifications, is the ability to keep up with the literature. I have seen some of the literature of Wellcome and the other places in Portland Place and in the medical sense the amount of literature that pours out from all around the world on this subject, it is impossible, is it not, almost impossible at any rate?

(*Dr Mathieson*) You have to be very selective in your reading and very specialty orientated.

1186. And devote a fair amount of time to it.

(*Dr Mathieson*) Yes.

1187. There is always this pressure on you. Yet you do not finish up with a structured acceptance of what steps you want to take. This seems wrong to me.

(*Dr Mathieson*) Yes.

1188. There is no other discipline where this occurs quite frankly.

(*Dr Chatterjee*) One other thing, my Lord Chairman, if I could add to that. One of the things that has been done in Cambridge to introduce something structured very early on in one's career, is the ability to qualify both in medicine as well as to undertake a PhD in a combined fashion. I think it is somewhat along the American lines and is laudable. It remains to be seen how the first graduates from this scheme will fare. I think what is important is to take it a step further and to provide structure during the training grades, during the registrar grades and thereafter to allow both research and clinical

activities to be dovetailed all along. For example, it was my experience when I was in the States that the people who came out of MD PhD programmes, went into their residency or fellowships programmes to obtain the required training, whilst maintaining a laboratory base supervising people to carry on the research to keep the momentum going. Eventually when they became attending physicians it was also much more acceptable to work in a fairly clinically circumscribed manner alongside their full-time colleagues in that environment. I think that is where the changes need to come here as well.

Lord Perry of Walton

1189. Are you suggesting that the norm should be that you do the PhD before you do the registrar?

(*Dr Chatterjee*) No I am not.

(*Dr Sandford*) It is merely one option.

(*Dr Chatterjee*) It is merely one of the options and I think it is something that has been introduced in order to address this question of getting people into science early rather than leaving it until we are perhaps burnt out.

Lord Gregson

1190. Are you thinking in terms of a research PhD rather than a taught PhD?

(*Dr Chatterjee*) Yes.

Lord Perry of Walton

1191. I would have thought that an awful lot of the medical graduates would rather get on with some clinical training before they start off to do the three year PhD?

(*Dr Chatterjee*) There is an argument in favour of that but then, of course, the argument is that you have lost out in terms of the science.

Lord Gregson] They have got older as well.

Chairman

1192. There are several universities now in the United Kingdom which are developing, for a limited number of people with this particular interest or expertise, MD-PhD programmes.

(*Dr Chatterjee*) Yes.

1193. Supposing you run out of impetus in research or run out of steam, would it be easy for you to go into a post as a consultant in the NHS with your specific and relatively confined programme of recent training?

(*Dr Chatterjee*) Yes.

1194. And, on the other hand, how easy is it for someone who has come up the NHS ladder to move aside when they demonstrate research expertise into a research appointment such as you hold?

(*Dr Chatterjee*) I think this is a difficult question because clearly in order to address the question of insecurity there does need to be some cross talk between the two parts. Yet, on the other hand, I think we would argue that in some ways there should not be too much cross talk and the two parts should be

7 March 1995]

DR RICHARD SANDFORD, DR PETER MATHIESON
AND DR KRISH CHATTERJEE

[Continued]

[Chairman *contd.*]

necessarily kept separate and distinct. That is to say, those of us who have gone into medical research have done that of our own volition, we have made a clear choice and we are happy to play by the rules and to take those risks. What we would like to see is a clear career structure along that pathway. Equally, on the other side, whilst one can acknowledge that there are people who go into clinical medicine and perhaps relatively late in the day develop a taste for research and want to move sideways, I think one should discourage is making an element of clinical research or an element of research an obligatory component of the NHS training pathway. I think many of us have encountered colleagues who had to do two years of an MD as a stepping stone towards getting the next job or getting somewhere. I am not sure that I see the value of that necessarily.

1195. Well, it will be interesting to hear what your colleagues have to say about that.

(*Dr Mathieson*) I would certainly endorse that. My feeling has always been that we accept risk and are not frightened by that and have sufficient confidence in our ability and the institutions in which we are working to be able to deal with that. Really what we want is not perhaps more flexibility, because there is some flexibility in the system, but what we would like to see is an acceptance that the training requirements for someone who perceives themselves as having an academic university based career are really quite different from those which are required for someone to be an NHS consultant.

1196. Would it not, however, be the case that some degree of exposure to the discipline of research enlivens and enriches clinical practice?

(*Dr Mathieson*) I think that is a valuable argument and it is an argument which is often made in terms of constructing the ideal medical training requirements. I think what we are talking about is a period of basic science research equipping us to continue a career in research. I do not personally feel that a short period in which one is "exposed" to research is actually adequate training to be able to compete with basic scientists who make this their day's work and their full time employment.

1197. Not all clinical research is necessarily dependent even nowadays on basic science expertise, is it? There are many aspects of research in, for instance, the performance of clinical trials which may not require such expertise.

(*Dr Mathieson*) I think that is correct. Certainly the question I suppose is how much exposure one needs to a research discipline to be able to be equipped to do that. I think all of us have reservations about people doing research as a part of the clinical training scheme because they feel that it is required of them rather than because of any real desire to do it.

Lord Perry of Walton

1198. Some of us have in the past been talking about medical education and trying to introduce a combined intercalated BSc for medical undergraduates. Would you regard that as a better introduction to an understanding of the research

element than doing it during the clinical training period?

(*Dr Sandford*) I undertook that additional period and I think that is probably where I first realised that I was going to try and follow that sort of path. Yes, I think it is a very valuable component and obviously in most universities a significant number of medical students will be going through that path. Even at that early stage I think a lot of people are fairly clear in their minds whether they want to pursue full time clinical training or to mix in a proportion of research. I think it is going to be very much dependent on the individual and that is why I think flexibility throughout the whole period of training, both pre qualification and post qualification, should be permitted. I think all of these aspects in broad terms should be welcomed.

Lord Butterfield

1199. Many people did MDs which were part of the pathway to getting a consultancy but I am not sure that that has not operated to your advantage in that it has provided institutions which have got the right attitude towards research which might not have been present if people had not been exposed to setting up a hypothesis and testing the idea. I beg you to bear in mind the pluses and minuses of changing the MD structure. I do think it has in many cases helped people understand your problems and made the institutions more susceptible to helping you than might otherwise have been the case. One thinks of the situation in Eastern Europe where it did not happen, where everybody had to work for a system and there could not be any curiosity driven thinking.

(*Dr Sandford*) I think we would entirely agree and I think, given obviously the changes that we are probably coming on to discuss in terms of the Calman Report, sufficient flexibility must be maintained to allow that to happen. I think one of the issues that we are obviously very concerned with is that however medical training and clinical training is structured and whether or not that allows a period of research training, that structure should not automatically be imposed on other people who want to follow a different route.

1200. I am convinced by your argument. I am just worried that we do not get anti-research institutions through the people with the clinical drive not knowing what it is like, having setbacks in research.

(*Dr Sandford*) I would entirely agree.

Chairman

1201. We must avoid putting up impenetrable barriers between those on the one hand going up the clinical ladder and those on the academic ladder?

(*Dr Sandford*) Yes, I think an ideal environment in an academic institution would be where there is free talk between full-time clinicians, full-time scientists and those who fall in the middle, the clinician scientists. That provides a very valuable interface. I think both sides can contribute equally.

7 March 1995]

DR RICHARD SANDFORD, DR PETER MATHIESON
AND DR KRISH CHATTERJEE

[Continued]

Lord Perry of Walton

1202. You are arguing for flexibility here as people differ. Are you also arguing that there should not be a requirement that everybody does some research training?

(*Dr Sandford*) Yes. I think some people very clearly do not want to do any research training or they may want to take a sabbatical year to look at other aspects. There should be flexibility to take time out. They should not necessarily need to pursue research in its broadest terms.

1203. You think it would be counter productive even if they did not understand the output of research and therefore were not as able to implement the research in clinical practice?

(*Dr Sandford*) I would like to feel that medical education and subsequent clinical training under the guidance of a consultant should expose you to the literature and should expose you to the enquiring mind that is able to interpret that sort of research anyway. It should not be a two year block where that is when you learn it and you have not learned it before. I think it should be a continuing process that should be available to everybody, and hopefully it is via different routes such as postgraduate centres that operate in every hospital.

Chairman

1204. If everything went right where do you each wish to be ten years from now? Do you all want to be Professors of Medicine?

(*Dr Sandford*) If I may start, yes. I would certainly like to have my own research department but very much, again, encompassing clinical components and the research components to provide a very broad overview allowing those people on the clinical side to pursue that and the people on the research side to continue that unhindered.

1205. Do you see any prospects in this country of there being established Chairs or whole-time directorships of clinical research institutions as distinct from teaching posts involved with research such as most Professors of Medicine are engaged in at the moment?

(*Dr Sandford*) I would like to see that. I think the position we perhaps find ourselves in, is that we have actually quite a unique opportunity. As a cohort of people we are coming through on a fairly new type of fellowship, the Clinician Scientist Fellowship, it is only now that people who have gone through that fellowship are coming forward. In a sense we are driving how medical research may be conducted in the future. One would like to see that the people who are awarding funding for these sorts of fellowships will then follow that on and make further funding available at senior fellowship level and beyond to Research Council funded Chairs and in a sense we can direct exactly what those Chairs are going to be responsible for. Yes, I do consider that a distinct possibility that we would like to see.

Lord Gregson

1206. Unfortunately it is not the same people who do the funding so there is no continuity available to you, is there? The people who fund the clinical

research centre are not the people who are funding the scholarships, they are miles apart. What should happen? What should be the route of creating clinical research centres?

(*Dr Sandford*) I think perhaps rather naively should it not be that there should be considerably more cross-talk between people who are on the one hand funded by the research councils and research charities but we are holding these posts within the NHS university environment, so due recognition on the one part obviously exists and that is where we should be doing the research. Presumably on the other hand, from the NHS there is obviously due recognition that we have an important role to play there so it seems only logical that in fact everything should marry together to follow up the cohort of people that are doing that.

Lord Gregson] In a sense though that is the NHS, is it not? They are the only people who could find such funds. Do you see the NHS doing that under the present system?

Chairman] It is not impossible, of course, that charities or other bodies may in time fund such long-term appointments with an NHS link but with a clinical research responsibility.

Earl of Selborne

1207. I think we are touching here on the fundamental issue of Culyer and the interface between your fellowship research and the NHS researchers. I think Culyer acknowledges that the skills to commission research and development within the NHS are scarce and he recommends R&D Commissioning Units, part of which, I am sure, is to provide an interface with yourselves. Would you like to comment on how effective you think these R&D Commissioning Units might be to bridge the gap we are talking about?

(*Dr Mathieson*) I think the idea of having an identifiable source of funding under one which can submit applications, have them peer reviewed and by all means subject to assessment of productivity and outcome, having some sort of identifiable funding scheme into which clinical research applications could be made will, I think, make that easier and provide an easier route to the funding of research. I think the people doing it may well be people like us having departments where perhaps they have a basic science background and a basic science training but then wanting to apply that more to clinical questions. I think the question about where we aspire to be and running our own departments and what we would do with those departments may well involve a commitment to taking on board the idea that we should be doing more clinical research and more health service driven research.

1208. In your written evidence you do make some quite strong observations. You say that there needs to be a fundamental rethink in the way that research is viewed by health service administrators and planners. Do you feel that this report addresses these deepseated concerns that you expressing?

(*Dr Mathieson*) I think it starts to. What some of us are worried about behind that kind of statement is the short-termism, if you like, of goal directed research and for all of us, certainly in my personal research, that is a long way from a clinical

7 March 1995]

DR RICHARD SANDFORD, DR PETER MATHIESON
AND DR KRISH CHATTERJEE

[Continued]

[Earl of Selborne *contd.*]

application. It would be very hard for me to justify on productivity or on likely developments of new treatments or new investigations the sort of thing that I have done day to day. It is the worry about short-termism I think which leads us to make that kind of statement.

Chairman

1209. Do you think that Calman is going to have an adverse effect upon people wishing to go into research training?

(*Dr Mathieson*) My personal view is that yes, it could do. It can be used to our advantage I think. The question, as we have already discussed it, of the idea of separate career paths for would-be academics and clinicians I think could be served well by the Calman proposals in that there is a set period of clinical training which is mandatory and which all of us have to fulfil. What one does with the extra years of training is largely up to the individual. There is a danger that the Calman requirements might punish people for wanting to do research in that there is no statutory requirement to do research, or indeed any identifiable period in which one would do it. As I say, in the present situation we could turn it to our advantage by saying that we would fulfil a Calman type clinical training programme and in addition we have done some research which has equipped us with other skills.

1210. Would you wish to identify other countries where the career path for clinical academics is more satisfactory than in this country?

(*Dr Chatterjee*) My Lord Chairman, I already alluded to that somewhat earlier. It simply makes the point that, for example in the United States, things are much more structured and fully developed at each stage.

1211. Is that not in the end an issue almost wholly of money?

(*Dr Chatterjee*) Yes.

1212. After all in Harvard the staff/student ratio is about five to one with five staff to one student whereas in this country it is about one member of staff to seven or eight students in clinical medicine.

(*Dr Chatterjee*) I accept that but I think it may also be partly to do with the philosophy as well. There may be more acceptance there of the clinical scientist working within a clinical environment than there is in parts of the United Kingdom.

Lord Gregson

1213. Do any of you have experience of Germany at all? I got the feeling when I was in Aachen that there was a much closer relationship between clinical research and the hospital requirements which are based on the university.

(*Dr Chatterjee*) No.

Lord Nathan

1214. I would be very interested to have your comments on the career prospects for scientists from non-medical disciplines working in clinical

departments. I have in mind physicists working in connection with cochlear implants and so forth, cardiac departments and no doubt many others.

(*Dr Chatterjee*) Perhaps, my Lord Chairman, I can comment on this one. I think the problem for the non-clinical scientists is in some ways worse than for clinical scientists because there really is no defined career path at all. Whilst many of us have graduate students and postdoctoral fellows working within our groups it is much more difficult to see where they go from there. For example, it is difficult to find permanent established posts for non-clinical lecturers. I think that is a matter for serious concern.

1215. What would your suggestions be?

(*Dr Chatterjee*) I think explicitly to provide something that bridges the gap from the postdoctoral fellowships through perhaps a career development post within a clinical department through to a full university lectureship, exactly as one might have in a basic science department. Otherwise I think the danger is that many of us in our groups are going to be relying forever on cycle after cycle of graduate students and post-doctoral fellows who will then get trained to a certain level and leave.

1216. What actually happens to those who have been through your care? What happens to them next?

(*Dr Chatterjee*) Well, I cannot speak from personal experience in my own laboratory, but my wife, for example, is a non-clinical scientist working within the Health Service. Her experience has been that during the course of her career she has made several moves to different institutions before she finally achieved permanent status and I think that was not totally necessarily always through choice. There were one or two places during her training where she would have liked to have carried on, if the opportunity had been there but there simply was not a career path or a career track to do so.

(*Dr Mathieson*) If I may just say, my Lord Chairman, I think it is very important to recognise that clinical research depends very heavily on basic science input and those of us who have post-doctoral fellows have the ever-present worry of losing them to industry where the financial benefits and also the security are very much greater. Because of the constraints on our time as we are having to do clinical training and having to do clinical work, inevitably we depend on having other people as pairs of hands to continue the research and I rate very highly the basic science of PhD students and postgraduates in that respect. There is always a worry of losing them, so the idea of having an improved career path would have direct benefits, I think, for clinical research.

Lord Butterfield

1217. There is the other side of it though that because there is an escape route for those scientists into industry, say, you have not got a terrible blockage on the ladder for the young people coming up looking for an opportunity. One of the big problems that has to be settled somewhere or another is yes, we want to see a way for you to get your chairs (but not in America, if possible), but what are we going to do to clear the chairs to make way for you? It is all right for Lord Perry and myself because we

7 March 1995]

DR RICHARD SANDFORD, DR PETER MATHIESON
AND DR KRISH CHATTERJEE

[Continued

[Lord Butterfield *contd.*]

got out through university administration, but there was jubilation at Guy's when they heard about my job. I suppose we could make some more medical vice-chancellors.

(*Dr Mathieson*) Make some more chairs.

Chairman

1218. So you would be very happy to commend the policy introduced in the Health Service in the last few years of funding academic appointments on Health Service money?

(*Dr Mathieson*) Absolutely, as long as there is built into that protected research money. I think the danger is forming an academic post and expecting of it the productivity of a National Health Service post.

1219. Some 24 years ago I was successful in attracting a major endowment from a charity to create in my department a chair of experimental neurology to be held by a doctor with supporting staff, and there were two successive appointees, each medically qualified, and each with a good record and background of training in research who were extremely productive. But after five or six years, each of them moved on into the chairmanship of a standard university department where they saw a greater scope for their expertise and at the third attempt the chair was filled by a scientist without medical qualifications. Are you suggesting that with people like yourself there is a new breed arising of people who might be prepared to take whole-time research chairs?

(*Dr Sandford*) Yes, I think that is certainly one area that one has to consider, but I would also suggest, as we said a little bit earlier, that I think we are a new cohort coming through and again we are looking very closely at where we are going to go and we have already taken the decision that the clinical component of our future careers is going to be substantially smaller than perhaps it may have been in the past and I would certainly see a number of

people taking on that sort of area. Certainly in the laboratory where I come from there are clinicians, clinically-qualified scientists, who now have no clinical component and who have taken the step of going into full-time science, so this is happening really.

(*Dr Mathieson*) I think your personal experience is interesting in that at the present stage certainly personally of my career there are some aspects of being a professor of medicine which worry me. What I quite enjoy doing is spending time at the laboratory bench and one wonders how with increasing seniority the amount of actual protected research time and laboratory time may be greatly eroded. It is interesting that you have actually found the converse and that people aspire to leaving that behind.

1220. That is many years ago. It may have changed. The point I was making was not to suggest that such an appointment would be totally without clinical contact, but that the clinical contact would be limited; do you think that is likely to be an attractive option?

(*Dr Sandford*) Yes.

Lord Flowers

1221. Would you want to be a patient of somebody whose clinical contact was limited?

(*Dr Mathieson*) I would be perfectly happy to be, but obviously that is a self-justification of all of us and we have to be careful to defend that. I think the current length of clinical training is unnecessarily long and there is no need to be involved 24 hours a day in medical care in order to maintain a good standard of care, and again the other practical point I suppose is that in being in institutions with other like-minded individuals, there is a pool of people whose expertise can be called upon.

Chairman] Thank you very much.

Footnote by the Association of Young Medical Scientists

In providing evidence on the possible impact the Calman Report will have on medical research and careers in academic medicine, we would like to further qualify our statements. Whilst welcoming the proposals in general that seek to shorten the period in training by establishing a unified training grade, we feel that the necessary commitment has not been given to those seeking a career in research. As I believe was obvious from our evidence, we feel that an academic career requires a different training programme, a parallel track rather than a fast track as it is currently perceived. The complete definition of the responsibilities and priorities of the academic should lead to a revised training programme being designed in the same manner that each speciality will be defining their own.

16 March 1995

Memorandum by the Royal College of Nursing

The Royal College of Nursing thanks the Select Committee on Science and Technology of the House of Lords for the invitation to give evidence on medical research and the NHS reforms and accepts with pleasure. The College is also grateful to have been asked to give oral evidence and is doing so through its Research Advisory Group members and Research Committee.

7 March 1995]

[Continued

1. THE ROYAL COLLEGE OF NURSING

1.1 The Royal College of Nursing (RCN) is the world's largest professional union of nurses, with more than 305,000 members. It offers a wide range of services including professional advice, courses, seminars and conferences. The RCN also provides up-to-date information about developments in nursing and health care. It has the largest nursing library in Europe. The RCN promotes the interests of nurses and patients on a wide range of issues including standards of care, through working with Governments, MPs, other unions, professional bodies and voluntary organisations.

1.2 The RCN Council is the governing body and is made up of 25 democratically elected members representing the English regions, Northern Ireland, Scotland and Wales, and the College's student membership. Policy is made either directly by RCN Council or through one of its committees. The RCN has a President and Deputy President, both of whom are elected by the membership as a whole. The Chief Executive of the RCN, responsible for executing RCN policy, is the General Secretary.

1.3 Continuing professional education is a central tenet of the RCN's Royal Charter. Its main education function is co-ordinated through the Institute of Advanced Nursing Education (IANE) in London and a number of joint educational units in Belfast, Cardiff, Edinburgh and Leeds. The Institute has a Board of Governors constituted within the Royal Charter. As an integral part of the RCN it is a designated institution of higher education. As such it receives public funding from the Higher Education Funding Council for England for its award bearing courses.

Research and the Royal College of Nursing

1.4 One of the first government-funded nursing research projects was undertaken in the RCN in 1965 led by Baroness Jean McFarlane. This commitment to scientific enquiry has continued with the support of a number of initiatives. These include the setting up of the Daphne Heald Research Unit in 1982, a research advisory group for members, and a partnership with the National Institute for Nursing in Oxford which is a national centre for practice development, research and clinical audit. Both primary and applied research are supported and there is a growing commitment to developing effective ways of implementing research findings in practice.

1.5 The RCN Research Committee advises Council on policy related to research and steers the overall direction of RCN research activities. It is supported by a Research & Development Adviser and members from the Research Advisory Group. The research focus of the Daphne Heald Unit has been on primary health care, practice and policy, care of the elderly and nurse specialist roles. The National Institute for Nursing has a number of integrated programmes covering both primary and secondary care. In addition to clinical research the RCN supports studies on the nursing workforce, patterns of employment and job satisfaction. The RCN library houses the largest collection of Masters, MPhil and PhD theses of research by nurses in the United Kingdom (the Steinberg Collection).

1.6 In addition to supporting the research unit the RCN has published key nursing research in its Research Series, runs an annual scientific conference organised by the Research Advisory Group and is involved in the European Workgroup of Nurse Researchers. Most recently the RCN has been involved in two major initiatives on nursing research, namely the Taskforce on the Strategy for Research in Nursing, Midwifery and Health Visiting (Department of Health, 1993b) (Appendix 1) and the setting up of a new Centre for Policy in Nursing Research to be established jointly by the Department of Public Health Policy, London School of Hygiene and Tropical Medicine and the Royal College of Nursing (Appendix 2).

Evidence to the Committee

1.7 In the light of the above developments the RCN welcomes the invitation to give written evidence to the Select Committee inquiry into medical research and NHS reforms. The RCN in collating its written evidence has drawn widely from experienced researchers in nursing and health services research. The written evidence has been compiled by Professor Alison Kitson, Director National Institute for Nursing and Chief Officer responsible for research at the RCN; Dr Senga Bond, Director of the Nursing Programme in the Centre for Health Services Research, University of Newcastle Upon Tyne and Vice-Chair RCN Research Advisory Group; Professor Sally Redfern, Director King's College Nursing Research Unit and member of the RCN Research Advisory Group and Ms Ann McMahon, Research & Development Adviser for the RCN.

1.8 Other professional colleagues consulted include Professor Karen Luker, Professor Maggie Pearson, Professor David Thompson, Professor Jenifer Wilson-Barnett, members of the RCN Research Advisory Group and members of the RCN Research Committee. Those consulted bring with them a wide range of personal experience in working with the NHS Research & Development strategy. They work in Health Services Research Units, leading Departments of Nursing as members of regional research committees or have sat on advisory groups such as the Taskforce on Nursing, Midwifery & Health Visiting Research, the group looking at Supporting Research and Development in the NHS (the Culyer Committee) or on the Central Research and Development Committee (CRDC).

7 March 1995]

[Continued

1.9 The evidence has been organised according to the three questions set out in the call for evidence.

2.0 THE NHS RESEARCH & DEVELOPMENT STRATEGY

2.1 The RCN wishes to acknowledge the importance of the earlier report from the House of Lords Select Committee on Science & Technology (1988) *Priorities in Medical Research*. The report initiated the train of events which have led to many positive developments for all health care professionals.

2.2 We would also wish to congratulate Professor Peckham and his colleagues in successfully raising the profile for research in the NHS through securing more funding and establishing a national research infrastructure. We particularly commend the stance taken by Professor Peckham and his team in promoting health service research as an important contribution to knowledge generation and improving services (Department of Health, 1993a).

2.3 We agree with the vision as articulated by Professor Culyer and his team in the document *Supporting Research and Development in the NHS* (Culyer Committee, 1994) that R&D is one of the main ways to improve health and the quality of health care and, that it is one of the keystones of a knowledge-based evaluative culture in the NHS. In order to achieve this ambitious objective the R&D strategy must follow explicit priorities, encourage wide participation in indentifying research needs and involve all health care disciplines.

2.4 Those working directly with patients must be reminded constantly of the purpose of research which is to promote beneficial change. Consequently there must clear systems developed which reconcile the conduct of research with the future organisation of health services taking into account such change as the move to primary and community care, greater patient throughput, greater volume of outpatient and ambulatory care, changes in professional roles, boundaries and skills and changes in the expectations of patients.

2.5 The RCN believes that such contextual change will also require an equivalent shift in the variety of approaches used to undertake research. The range of existing methodologies employed by different groups in the field of health service research need to be rigorously tested. There is also a need to monitor their development in order to meet the increasing demand for sophisticated research designs to be employed to answer complex questions. We believe that the NHS R&D strategy has been particularly successful in laying the foundations for such shifts in culture. We can also report positive changes that have enabled nurses pursuing academic research and clinical careers to be more deeply involved in strategic planning and policy development.

Nursing's contribution to the R&D strategy at region and academic level

2.6 We have evidence across each of the new regions of widening membership of the regional R&D committees. Most have at least one nurse member. Also national committees are increasingly inviting other health professionals to contribute to the strategic and policy development of the R&D agenda. This is seen as a very positive step and one which embraces the principle of recognising the contribution of all health professional groups to promoting beneficial change. We would also interpret it as enabling the full incorporation of nursing and research in nursing within the NHS R&D structures and processes as articulated in the Taskforce Document (Department of Health, 1993b, p.18).

2.7 Investment in training for R&D has also had benefits for nursing. Increasing numbers of nurses are taking advantage of MRC/NHS fellowships although in real terms the numbers are still small. More encouraging are the initiatives of some regions where their health service research units have a nursing sector built into them funded through the Regional Health Authority. Both Trent and North Western Region have taken this model and these structures are reported to be working well. We would also welcome consideration of developing the concept of nursing practice research units similar to the model successfully developed by the NHS R&D Directorate in South and West Region for general practice research.

2.8 We also applaud the Department of Health's continuing support of the three Ph.D studentships it funds annually and also the post-doctoral studentship. In the past these have been vital to training for research in nursing. However, we would welcome a much more integrated system of postgraduate training within the NHS where opportunities are open to all members of the health care team. We would also welcome more realistic assessments of the numbers of nurses put forward for such training. It has been estimated that through the protected time given to all senior registrars in the NHS (3,875; source Department of Health, 1994), the time amounts to the equivalent of over 750 full time posts. We would welcome similar schemes for clinical nursing staff.

2.9 We have evidence of much more collaborative work with medical and nursing colleagues working together in developing protocols and undertaking research; joint supervision of post-graduate students and greater willingness within academic departments of medicine to support the establishment of nursing chairs. However, despite these positive developments there continue to be areas where collaboration is neither understood nor encouraged, where research directors and academic deans hold traditional views of medical

*7 March 1995]**[Continued]*

research and where nursing academics reject opportunities to collaborate. In such places there is an unwillingness to embrace the opportunities offered by the R&D strategy and as a result nursing and paramedical staff have less opportunity to realise their contribution. As a consequence they become defensive and isolationist, reinforcing the stereotyped attitudes and behaviour which make it more difficult to break the vicious cycle. While we recognise this behaviour we believe that the opportunities created by the R&D strategy are sufficiently exciting and challenging to enable a new spirit of collaboration to be embraced.

Purchaser and provider level

2.10 Nurses in purchasing roles within commissioning teams have welcomed the R&D Strategy. They have identified the need for more data on the effectiveness of nursing and paramedical interventions. The effectiveness bulletins produced by the York Dissemination & Review Centre provide vital information upon which evidence-based health care can be purchased. We believe that every purchasing authority should employ nurses with experience in R&D so that evaluation and research are incorporated into the commissioning process. As commissioning teams are faced with more integrated health and social care the need for a broader caring perspective will increase.

2.11 At provider level there has been proliferation of service development posts for nurses, usually focusing on the implementation of research into practice. These posts are usually linked to clinical audit activities but there is also an expectation that postholders are involved in research. This is unrealistic as often the postholders have had no research training nor are they given protected time to develop such skills. It is important that at local level there is a clear understanding between service development and the role of skilled individuals in initiating R&D activities. The consequences of confusing these roles have been described in the Taskforce Document (Department of Health, 1993b) and confirmed by a recent survey of nursing developments in Oxford Region (Kitson & Currie, 1994). The relationship between research, development and service development within a wider framework of a knowledge-based evaluative culture will be discussed in more detail later (para 3.13).

2.12 Despite these developments a continuing problem for nursing is not being able to get the best out of the reforms. An infrastructure for promoting nursing research and development does not exist nor has there been a tradition as within medicine to address poor quality patient care by creating a chair, attracting high calibre staff and raising the standard of teaching and research, funded by regional money. Similar initiatives are needed for nursing. Encouraging developments such as those between trusts and universities in Newcastle, Sheffield and Hull have begun to establish clinical chairs in the nursing specialties of mental health, gerontology and community nursing.

The NHS Research & Development Programme: the nursing contribution

2.13 The RCN welcomes the efforts made by the Central Research & Development Committee (CRDC) to involve organisations in the commissioning process. It also welcomes the mix of topics, client groups and organisational settings as programme leads for the research exercise. However, there is still a tendency for subject areas to exclude the nursing and paramedical contribution and to be medically led or focusing on clinical treatments. We would urge the CRDC to extend its notion of treatment to include the management of chronic illness and the wider context of "illness" as it affects the quality of life, morbidity and longevity of the individual patient, carers and family. Such studies are complex but urgently need to be undertaken in greater numbers to inform health policy and practice.

2.14 We see it as a challenge for our own profession to ensure that our views are presented in a cogent way. We also applaud the CRDC's role in encouraging collaboration between centres, between disciplines and encouraging the utilisation of a wider range of methodologies. We would also hope this spirit of collaboration continues despite the growing market forces and competitiveness developing within health and academic institutions.

2.15 We believe that the credibility of the nursing contribution to the scientific community will be determined by the extent to which nursing fulfils its promise and potential as a clinical service committed to investigating the effects of clinical interventions on clinical outcomes. Nursing also has a major contribution to make regarding the organisation of services on cost-effective and patient-centred outcomes.

2.16 This can be achieved within the current R&D strategy by taking cognisance of the following:

- including the nursing dimension to the clinical topic under investigation
- establishing a strong nursing contribution to the Cochrane Collaboration work
- ensuring that effectiveness bulletins disseminated from York include information appropriate to all members of the health care team
- involve the wider professional team in health technology assessment

7 March 1995]

[Continued]

- acknowledging the shift in health care provision and therefore changes in lead interventions eg increase in chronic complex illnesses, greater involvement in education, information, family support and the move towards residential, nursing home and social care all requiring rigorous evaluation
- preparing nurses and doctors for their changing roles in the 21st century where health and social care boundaries will diminish thus requiring greater collaboration (Department of Health, 1993c).

3.0 CULYER REPORT

3.1 The RCN in principle commends this report and congratulates Professor Culyer and his team for tackling a vitally important and complex area. It sets out the key issues that enable high quality research to be undertaken across a variety of settings. It also acknowledges the need to set up a proper research infrastructure within the services and support ongoing education and training needed to develop the research capacity across a range of professions. We have identified areas where we believe further discussion is required.

Hidden cost of the nursing contribution to medical research

3.2 It is well known that nurses are often recruited as data collectors for medical studies, particularly randomised controlled trials. This hidden cost was identified by the Medical Research Council group (House of Lords 1995, p.47) as a significant service cost incurred by the NHS. There is little information currently available as to how additional nursing time is negotiated at local level; we do not know the impact it has on the quality of patient care nor how nurses gain from the experience. Nursing has not been part of the Service Increment for Teaching and Research (SIFTR) arrangements and therefore it is difficult to tell what the cost to the nursing service has been in deploying staff in such a way. Also with changes in junior doctors hours, increased throughput and moves to community care the service costs of research will increase. Unless nursing budgets account for this the quality of patient care will be affected.

Hidden cost of nursing research

3.3 It is important to emphasise the wholesale move of nursing education from Colleges of Nursing into higher education. Policy arrangements similar to SIFT or SIFTR to accommodate the move have still to be formulated. In fact, traditionally universities are remunerated for nurses at the social science level; nursing in the university sector is not recognised as a practice discipline like medicine. This anomaly has put great strain on both the universities and on the service to maintain appropriate teaching as well as research.

3.4 Provider units have not been given additional support to cope with the extra demands experienced when nurses undertake research or are involved in undergraduate and postgraduate nurse education. Without equivalent SIFTR arrangements academic nursing departments and trusts have evolved a range of service agreements to promote a more research-based culture. Such roles include joint appointments between academic and research units and services such as clinical lecturers, lecturer practitioners, research clinicians. These roles go some way to acknowledging the extra cost of conducting research but are limited in many ways. Major problems are their lack of direct accountability either to the academic unit or to service, the lack of clarity of the clinical accountability and autonomy of the post and their incongruity with conventional clinical nursing posts.

3.5 The consequence is that nursing research continues to be perceived as illegitimate activity in the sense that it has no formally recognised funding structure sanctioning its work from region, through purchaser to provider level. This position reinforces the perception that it is insignificant and superficial despite protestations from those undertaking the work. We believe this is an issue of fundamental importance and one which we do not think the Culyer report has dealt with in any detail. We would suggest therefore that urgent attention be given to the practical details of how university based nursing education and research are to be supported in the new NHS structures.

The infrastructure to support the nursing contribution to R&D

3.6 Conditional upon the resolution of issues identified in 3.5, the RCN supports the general principle of building up a sound R&D infrastructure in a relatively small number of centres of excellence. We would require academic trusts to demonstrate the integration of undergraduate, postgraduate, continuing professional development, research and clinical leadership for all health care groups. We also endorse the statement that we need to care for patients using the most advanced concepts and provide sophisticated diagnostic treatment and care centres to support research and teaching. Again we would expect such centres to be exemplars of the best and most effective collaborative research, education and clinical care. We are encouraged by developments such as the Centre for Primary Health Care at the University of Manchester which has made links with the Department of Nursing and the MRC HSR initiative which has linked with

*7 March 1995]**[Continued]*

the nursing programme at the University of Newcastle HSR centre. These developments reflect positive collaboration and the growing respect between professionals.

3.7 We would urge CRDC to consider how they are going to encourage infrastructure building in other professional groups including nursing in order to bring them to a level where they can contribute equally with those who have had support for a longer period of time.

3.8 With the proposed demise of regional health authorities in 1996 careful consideration will be given to educational support structures for academic medical graduate education. We would ask that equal consideration be given to nursing and paramedical groups. A mapping exercise must be undertaken to evaluate the extent of the infrastructure investment needed for nursing and paramedical groups in order to establish an equitable and effective system aiming to promote beneficial change through establishing a knowledge-based evaluative culture enhanced by all health care professionals.

3.9 We are encouraged by the spirit of the R&D strategy and by the Culyer Report which identify the need to develop an appropriate research capability in each of the professions allied to medicine (Culyer; para 2.49). We also accept the need for the NHS Executive to hold budgets credited from the levy to all purchasers (Culyer, para 3.33). However we would point out the need to ensure proper consultation with all professional groups and assessment of the R&D need and capacity and determination of geographic location. The RCN would be happy to advise on the national aspect of this and would be expected to be formally consulted.

Developing a high quality research workforce across the health professions

3.10 Nursing shares with every other professional group a shortage of high calibre, well trained researchers to lead teams of workers. Given the size of the nursing workforce (just over 500,000) the number qualified to lead the nursing research agenda seems even less. Short term solutions and long-term investments are needed to begin to answer policy questions such as:—

- how many nurses should be trained to post-doctoral level in order to lead the nursing contribution to the R&D agenda?
- how many nurses should be trained to Masters/Doctoral level to lead the nursing contribution to the purchasing and provider agenda?
- how many nurses should be trained to post-doctoral level to lead academic nursing departments?
- how many nurses need to be involved in undertaking primary and applied research?
- how do we ensure that all nurses are using the findings of research and have developed the critical appraisal skills that will enable them to be questioning practitioners, able to question their own practice and use research findings effectively to improve patient care?

3.11 We recognise that research training will be considered by another sub-group of CRDC and is not of central concern to the recommendations of Culyer. However we cannot stress our concerns strongly enough regarding the urgent need to invest in a long-term programme of research training for nurses. We have already mentioned the modest benefits accrued from Regional initiatives (para 3.6), the MRC/NHS fellowships (para 2.7) and the Department of Health funded fellowship (para 2.8). However unless the plans for infrastructure funding acknowledge the significant investment needed for research training then little lasting benefit will be achieved.

3.12 A central theme to the R&D infrastructure funding and training agenda is guidance on careers in nursing research. We strongly advocate that nursing posts from junior staff nurse to senior sister/clinical specialist be designated as training posts with protected study time. We also recommend that the conclusions of the Taskforce Document (Department of Health 1993, rec. 15) are actioned to standardise the salary scales of clinical nursing staff undertaking research. We strongly encourage the Committee to consider the urgent need for appropriate research training for nurses in lead commissioning and provider posts. In addition those nurses wishing to following research as a career need to be given the same opportunities as colleagues from other disciplines in terms of training time, remuneration and training opportunities.

Research and development and service development

3.13 The RCN recognises that this topic fell in the margins of the terms of reference of the Culyer Report. We would however wish to state our concern that a thorough and informed debate is undertaken on how the R&D agenda informs service development. We are concerned that the stark separation between R&D and service development symbolised by funding arrangements may be communicating mixed messages, namely that research continues to be more important and academically acceptable than implementing research into practice or helping practitioners to change behaviour. In fact we find it difficult to understand how one can justify increased expenditure on clinical research if one then does not require some systematic way of getting that research into practice. While there are some convincing arguments about keeping service development at purchaser/provider level there may be equally convincing arguments about utilising a levy system to

7 March 1995]

[Continued

support large multi-centre implementation programmes which require rigorous evaluation, thus producing new information that can be generalised to other settings.

3.14 The RCN would welcome informed dialogue on this issue using the expertise of educators, social psychologists and organisational theorists as well as experienced researchers and clinicians in health care.

Other points from Culyer

3.15 We support the need to foster a spirit of enquiry which develops from good clinical leadership, commitment to improving patient care and good team work. We agree there should be local arrangements to include pre-protocol hypothesis generating, curiosity driven research which is open to all professions.

3.16 The issue of referrals must be considered more carefully, not only across purchasing and geographical boundaries but increasingly across professional groups. (This last point will be developed under para 4.2.)

3.17 The composition of the proposed National Forum must include those organisations which fund nursing and paramedical research. There may even be an issue about encouraging the more established charitable funding bodies to reconsider their definitions of medical research to encompass the broader health service, collaborative approach as embodied in the R&D strategy. The RCN would also be happy to contribute to this forum in whatever way is considered appropriate.

4.0 OTHER CHALLENGES AND OPPORTUNITIES

4.1 We have already identified a number of key issues from Culyer that need to be considered in more detail by the nursing and therapy professions. These include infrastructure for research, the cost of nursing research, training strategies and the relationship between R&D and service development. Briefly the other areas we see as requiring attention include

Access to patients for research purposes

4.2 The traditional system where consultants gave permission for their patients to be included in research is increasingly giving way to a more fragmented situation. When patients are moved from NHS locations to nursing homes, to social services and home it is not clear *who* is responsible either for the medical, nursing or social care of patients, *who* gives permission to approach the individuals and *what* mechanisms exist to receive ethical approval. The RCN believes that guidance on this topic will become a matter of some urgency.

Nurse managed care

4.3 There is a need within the NHS to explicitly acknowledge the increasing trend for other professionals to take the lead on managing patient care. Such developments will only be acceptable if those groups involved enshrine research based practice. The move towards this comes at a time when nursing skill mix and economic constraints militate against establishing and maintaining top quality teams. We urge the committee to consider how they can encourage where appropriate the development of nursing led services underpinned by research based knowledge. We have evidence to suggest that nursing led interventions with chronically ill patients and the worried well can lead to better quality, more cost-effective health care.

5.0 SUMMARY OF KEY POINTS

The RCN's evidence has covered a wide range of issues. We would however like to summarise what we believe are the most important points for the nursing profession to realise the potential of the NHS R&D strategy.

5.1 The most urgent priority is to obtain clear direction on the infrastructure funding for R&D (paras 3.6–3.9). The emerging structure must take consideration of

- the move of nurse education to higher education (para 3.3)
- the lack of any formal infrastructure for nursing research at local level (para 3.4)
- the failure to designate staff nurse posts as training posts with protected study time (para 3.12)
- the lack of any clear guidance on a nursing research workforce strategy (para 3.10) or nursing research career pathway (para 3.12)

The setting up of nursing practice research units (para 2.7) and the development of clinical chairs in nursing specialties (para 3.6) are useful models to encourage.

5.2 There is a need to encourage the continued integration of nursing research into health service research units and academic departments of medicine (para 2.9). This will be facilitated by the inclusion of nursing dimensions to research topics under investigation (para 2.16), joint research training programmes and

7 March 1995]

[Continued

fellowships (para 2.7), evidence of collaborative research (para 3.6) and formal and informal links between units and departments (para 3.6).

5.3 Greater conceptual and operational clarity are required regarding research, development and service development (para 3.13). The difference between hypothesis generating and hypothesis testing research should be stated (para 3.15). Evaluation research needs to be considered in the context of testing the effectiveness of implementation strategies (para 4.3) and the impact of separating these areas should be considered in the context of the overall objective of creating a questioning evaluative culture (paras 2.3–2.5).

5.4 Nursing research is planning the shift in health care delivery to the community and particularly to residential care, nursing homes and domestic settings (para 4.2). There is a major research and development agenda for the nursing profession in partnership with others to promote better care by investigating patterns of care, treatment and support needed to help the increasing number of frail and vulnerable people in society (para 4.3).

5.5 Implicit in all of the evidence is the need to recognise the importance of producing confident, articulate nurses who are capable of developing a knowledge-based evaluative culture in the NHS (paras 2.3, 2.4).

We thank the Select Committee for the opportunity of submitting written evidence. We are happy to provide any additional material.

REFERENCES

- Culyer Committee (1994) *Supporting Research & Development in the NHS*. London, HMSO
- Department of Health (1993a) *Research for Health*, London, Department of Health
- Department of Health (1993b) *Report of the Taskforce on the Strategy for Research in Nursing, Midwifery & Health Visiting*. London, Department of Health
- Department of Health (1993c) *The Challenges for Nursing and Midwifery in the 21st Century*. London, Department of Health
- Department of Health Medical Manpower & Education Division (1944) Medical and Dental Staffing Prospects in the NHS in England & Wales, 1990. *Health Trends*. 23, 132–5
- House of Lords Select Committee on Science & Technology (1988) *Priorities in Medical Research*. London, HMSO
- House of Lords Select Committee on Science & Technology (1995) *Medical Research and the NHS Reforms*. London, HMSO
- Kitson A L, Currie V (1994) *Clinical Nursing Practice Development & Research Activity in Oxford Region, 1993*. Report No. 7. Oxford, National Institute for Nursing

APPENDIX 1

THE TASKFORCE ON THE STRATEGY FOR RESEARCH IN NURSING, MIDWIFERY AND HEALTH VISITING

1.1 This important work has been central in establishing a clear policy agenda for the nursing profession in relation to research. Key recommendations emerging from the document relate to the structure and organisation of the NHS research and development infrastructure as it facilitates and promotes nursing involvement in biomedical and health service research; research education and training; funding for research and integrating research and development.

1.2 The operationalisation of the strategy was seen as multifaceted, involving research councils, regional directors of research and development, statutory bodies, academic departments of nursing and professional organisations. The implementation process was also seen to involve individuals at different times and at different levels of cost. The Taskforce recommended that:

- (a) the full incorporation of the nursing profession and research in nursing within the NHS R&D structure and processes were to be implemented without delay
- (b) the expansion of opportunities for research training also was to start immediately, mindful that it would take several years to come to fruition
- (c) the full involvement of research councils in supporting training for nurses was required as a matter of urgency
- (d) an investigation of support required to develop nursing research in provider units and in the community was required immediately
- (e) an evaluation of the implementation and initial impact of the report be conducted within 18 months of its publication.

7 March 1995]

[Continued]

1.3 The RCN has worked with members of the Taskforce and with the Department of Health in stimulating debate on the topic and entering into dialogue with professional colleagues and funding councils on how best to realise a number of the targets. Much has been achieved but much still needs to be achieved if the nursing professions are to benefit long-term from the excellent opportunities offered by the new NHS R&D strategy.

APPENDIX 2

THE CENTRE FOR POLICY IN NURSING RESEARCH

1.1 It has been the case that nursing research is perceived as fragmented, lacking a clear strategy and vision and isolated from the wider body of research in the health arena. This view has been reinforced by nursing tending to argue for special recognition within the research community, and producing research which was of an inferior standard to other disciplines. Often nursing's choice of a social scientific paradigm neither encouraged collaboration with medical colleagues nor achieved sufficient funding support for it to develop. Consequently little growth took place despite modest investment and nursing research did not reach academic credibility and respect as quickly as it ought to have done. This unfortunate state of affairs is reflected in the most recent results of the first Research Assessment Exercise (Tierney, 1994).

1.2 Despite these discouraging events initiatives such as the Centre for Policy in Nursing Research indicate the commitment from other professional colleagues to see nursing research assume a significant place in the overall health care research agenda. There is now widespread recognition of the need for a new, national initiative to formulate a co-ordinated strategy for nursing research. This view was reached by the trustees of the Nuffield Provincial Hospitals Trust as a consequence of discussions at meetings organised by the Trust over the past three years, and has also recently been expressed by the Taskforce document (Department of Health, 1993b). At meetings organised by the Trust there was broad support from nurses, researchers, NHS research and development managers and others for the establishment of an independent centre. The trustees therefore decided to provide funding to make possible the establishment of an independent Centre for Policy in Nursing Research.

1.3 The establishment of the Centre as a joint initiative between the London School of Hygiene and Tropical Medicine and the Royal College of Nursing is seen as central to its ethos. This combination of both institutions will provide the Centre with both a strong, multidisciplinary academic base and the opportunity to facilitate and influence the development of policy.

REFERENCE

Tierney A J (1994) An analysis of nursing's performance in the 1992 assessment of research of British Universities. *Journal of Advanced Nursing*. 19, 3, 593-602.

Memorandum by JJA Robinson, FRCN, Professor of Nursing and Midwifery Studies, University of Nottingham

INTRODUCTION

As a nursing witness, together with Professor Rosemary Crowe of the University of Surrey, to the House of Lords 1987-88 Select Committee on Priorities in Medical Research, I have watched subsequent developments as an observer with certain vested interests. In submitting the following observations on developments in nursing research I trust that you may find them to be of some assistance in your deliberations. They are written from my perspective as Head of a relatively new department of nursing and midwifery studies (created in 1989) within an established university which prides itself on being research-led. It will, I believe, be apparent how inseparable are my department's interests in NHS research and that of the University in research excellence as demonstrated in the Higher Education Funding Council for England (HEFCE) Research Assessment Exercise (RAE).

1. DEFINITIONS OF NURSING RESEARCH

In reporting on a visit to the United States of America (USA) Volume I of the Report of the 1987-88 House of Lords' Select Committee on Priorities in Medical Research states that "Nursing research is perceived as essentially clinical" (HL Paper 54-1, Appendix 5, para. 61). I would respectfully submit that this definition is outdated, narrow, and would exclude recent nursing research both in the USA and the United Kingdom in areas such as the comparative study of patient outcomes using different grades of staff; patient satisfaction with specific areas of health care; the implementation of nursing educational reforms; and the historical study of international nursing institutions such as the International Council of Nurses.

7 March 1995]

[Continued]

Whilst the unequivocal definition of categories of nursing research has yet to be achieved, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) in responding to an invitation for representation from the HEFCE in connection with the 1996 RAE, recently suggested that the following categories for the classification of nursing research should be recognised:

- (a) Research into nursing, midwifery and health visiting as social, political, economic and practice phenomena in their own right, including historical and contemporary policy research on the professions;
- (b) The evaluation of specific nursing, midwifery and health visiting interventions, in particular, research in clinical areas of practice;
- (c) Research which includes nursing, midwifery and health visiting as components of interdisciplinary and interprofessional health services research, including workforce planning research; and
- (d) Research into the educational preparation of nursing, midwifery and health visiting practitioners at pre and post registration levels (Research Advisory Panel, UKCC, 21 December 1995).

Research expertise in the above categories may be found amongst both nurse and non nurse researchers. Research in each category may focus in whole, or in part, on one or several of the 15 parts of the UKCC Register and the numerous sub-specialisms within them. The generic term "nursing" is used below to encompass the three professions of Nursing, Midwifery and Health Visiting and their sub-specialisms.

2. THE ESTABLISHMENT OF THE NHS RESEARCH AND DEVELOPMENT DIVISION

The major influence of NHS Research and Development Division on my own academic department has been in the new opportunities which it has created to bid for research in those priority areas of health services research which have been identified centrally and then advertised and managed by the regions. For example, a study of the services for women with long term mental health problems which is located in my department and managed by Trent Health. The initiative has therefore promoted the involvement of nursing personnel in the health services research outlined above under 1c. The opportunities for nurse researchers to obtain funding in this area (whether alone or as members of interdisciplinary research groups) appear to have been far greater than they are, or ever were, from the research councils.

A positive benefit of this method of calling for bids has been in the promotion of interdisciplinary and interprofessional collaboration which it has engendered. Even when bids have been unsuccessful, the process of bidding has resulted in far greater interprofessional and interdisciplinary awareness of respective interests and strengths within different departments. This has led in turn to other forms of collaboration.

The only restriction on our own ability to bid at Nottingham has been the limitation of time in a new department heavily committed to the development of undergraduate and post-graduate nursing education (and this is a *major* limitation given the early stage of our development). In turn, this restriction is tied to the tremendous growth of departments of nursing in the university sector over the past decade (see section 4 below) and the acute shortage of opportunities to develop nurses academically in order to staff them. It is commonplace for nurses to be pursuing their own postgraduate degrees whilst working full-time in a university department. This continual development work is a constant drain on a department of nursing's resources and makes its presence a possibly less favourable option in a university which is dedicated to achieving high RAE ratings.

A further possible restriction lies in the relative RAE weighting which may be given to the respective departments collaborating in interdisciplinary health services research. If the "lead" department gains all the RAE credit, then future collaboration will be doomed.

3. THE INFLUENCE OF THE STRATEGY FOR RESEARCH IN NURSING, MIDWIFERY AND HEALTH VISITING (THE "WEBB REPORT", DEPARTMENT OF HEALTH, 1993)

The Taskforce on a Strategy for Research in Nursing, Midwifery and Health Visiting was established in 1992 on the initiative of the NHS Research and Development Division under the chairmanship of Professor Adrian Webb. Its brief was to consider the role of research in nursing, midwifery and health visiting and the research contribution to be made by members of these professions. Reporting in 1993, its recommendations included:

- the integration of nursing, midwifery and health visiting issues and researchers from these fields within the new organisational structures for R&D in the NHS;
- targeted investment in research education and training for nurses, midwives and health visitors;
- the identification of an enhanced range of sources and types of funding for research in nursing;
- an improvement in the dissemination and implementation of research and development in nursing, (Department of Health, 1993, para 5, page 19).

7 March 1995]

[Continued]

It is regrettable that despite the timely and appropriate recommendations from the Taskforce, our experience has been that the effects of the implementation of the Webb Report have been neither as open nor as beneficial as the impact of the NHS Research and Development Division itself. Compared with the central NHS initiative in calling for bids for health services research described in 2 above, bids for the nursing research described under 1b and 1d above do not appear to be advertised routinely. Anecdotal evidence suggests that monies for this research may have been allocated to favoured departments and agencies. If true, this suggestion raises serious questions concerning the independence of the researchers and the validity and reliability of their findings which, in turn, will have implications for the credibility for nursing research.

It appears that a simplistic, instrumental view of nursing research persists in some quarters. A further paradox is therefore that in assuming a linear "engineering" model for nursing research (Bulmer, 1982), the type of study currently commissioned takes little account of the social, political and economic contexts referred to in 1a above. We would argue, in my department, that this will make it no easier to bring about changes in nursing through research for, as currently delivered, nursing research frequently fails either rigorously to challenge received wisdom, or to facilitate the development of a "learning organisation". It appears, by contrast, that NHS Research and Development Division is addressing this issue with some vigour through the establishment of an Advisory Group to identify methods of implementing R&D in the NHS. It is not evident to what extent nursing research is currently included in this initiative.

At the time of its publication, the Webb Report also omitted any discussion of the conflicting demands of the HEFCE RAE on nurses in university departments (Robinson, 1993, enclosed). The Webb Report's recommendations for the establishment of education in research awareness and research methods for nurses have, in our experience, been overtaken by the effects of the implementation of Working Paper 10. It is now both harder for nurses to obtain study leave to attend such courses, and for academic departments to obtain funding to staff them. Hence one statement of strategic policy intent finds itself in conflict with another, yet both emanate from the same Government Department.

4. STANDARDS OF RESEARCH, AND RESEARCH EDUCATION

The growth of university departments of nursing over the past decade referred to in Section 2 above, has taken place almost entirely within the new university sector. It is virtually impossible at this stage to establish to what extent research features as a priority amongst their activities or what quality control measures for research, and research education are in place. For example, one teaching quality control measure, the external examiner with appropriate qualifications and experience, is a rare species hunted by departments to the point, if not of extinction, then certainly of exhaustion!

The demand by nurses for post-registration graduate and postgraduate education which includes some element of research teaching is almost insatiable. Demand for teaching on research awareness is already at a high level following the introduction of conjoint validation between Statutory Bodies and the higher education sector for pre-registration Project 2000 diploma courses. Such demand will be fuelled further by the UKCC requirements for Post Registration Education and Practice (PREP) which take effect from 1 April 1995. From that date, all nurses, midwives and health visitors will need to demonstrate at periodic, triennial, re-registration that they have up-to-date knowledge of professional practice for which they must have undertaken a minimum of five days study every three years. The parallel introduction of specialist, post-registration, nursing qualifications on the UKCC Register at diploma, degree and/or post-graduate levels will increase the pressure on academic departments to include the teaching of research as a basis for practice in all such courses.

It may be argued that critical, reflective, research-aware practitioners offer the best possible safeguard to the general public for the maintenance and improvement of standards of nursing care, and that therefore all such developments are to be welcomed. However, the question of the type and quantity of investment needed for the development of the staff in university departments who can teach at appropriate levels, whilst also carrying out their own research and, at the same time, maintain their clinical competence has nowhere been seriously addressed.

An alternative perspective arising from the implementation of Working Paper 10 is that Trusts are increasingly claiming to be able to provide the necessary in-service training in order to maintain the competence of their nursing staff. When combined with an increasing reluctance to accept outside researchers to carry out their investigations within Trust parameters, it does not take too great a leap of the imagination to see the potential for future conflict between the Trusts' interests and those of the higher education sector. The question which needs urgently to be researched is to what extent these respective positions contribute to, or detract from, excellence in nursing for the general public? A further urgent question concerns the extent to which research carried out in this environment can ever be independent.

In terms of research quality assurance in the university sector, it remains to be seen whether or not the new university departments of nursing and midwifery (which derive funding directly or indirectly from the NHS rather than from the HEFCE) are submitted by their universities in the 1996 RAE. Non participation where

7 March 1995]

[Continued

a nursing department's income is not dependent on the RAE outcome is entirely understandable. Yet participation in the exercise is one way that standardisation of research quality in the nursing professions might be achieved.

5. VARIATIONS IN MATERIAL REWARDS FOR STAFF IN DIFFERENT INSTITUTIONS

The above scenario of competing interests, expertise and skills is further distorted by the different reward systems in place within the NHS, the new university sector, and the established universities. In general, it is fair to say that an inverse relationship exists between the possession of sophisticated research skills and the level of remuneration which such staff receive.

The situation is becoming particularly acute in nursing departments in the established universities where non-clinical salary scales on which nurse lecturers are paid currently run at approximately 20 per cent less than the equivalent point for a nurse lecturer in an NHS college of nursing. There is therefore little incentive for nurses to improve their research skills to such a level that they become eligible for employment in an established university. This situation adds greatly to the pressures when trying to recruit appropriately qualified staff.

The cumulative effect of all these competing tensions may well be, eventually, to exclude nursing from the established universities. This is likely to diminish nursing's opportunities to contribute fully to interdisciplinary and interprofessional health services research, especially where it is associated with Medical Schools in the established universities.

6. CONCLUDING SUMMARY

In summary I would reiterate the following points:

- (a) To define nursing research merely as clinical is too narrow and restricted and not in line with the breadth and depth of current and future developments;
- (b) The expansion of nursing research into interdisciplinary and interprofessional research has been facilitated by initiatives taken by the NHS Research and Development Division. It will be necessary nevertheless to take account of the pressures on individual academic departments to obtain parity in the Research Assessment Exercise.
- (c) It is important that NHS R&D initiatives continue to enable independent bids to be made for *all* publicly funded research, and that the process is seen to be transparent, fair and academically rigorous.
- (d) The need to maintain and improve standards in nursing research, and nursing research education, is fraught with political and economic tensions. There is a need both for open debate on the issues and research into the development of models for nursing research delivery which maximise public protection.
- (e) The different policy agendas and resource allocation models which exist in the various institutions with vested interests in nursing education and research should be made explicit. The need to develop well-founded research-led departments of nursing in the established universities should be recognised. This is in the interests of good health services research as well as being in nursing's wider interests.

REFERENCES

Bulmer, M. (1982) The uses of social research. Social investigation in public policy-making. Contemporary Social Research, No. 3. London, George, Allen and Unwin.

Department of Health (1991) Research for Health. A research and development strategy for the NHS. London, HMSO

Department of Health (1993) Report of the Taskforce on the strategy for research in nursing, midwifery and health visiting. London, Department of Health

Robinson, J. (1993) Nursing and the research assessment exercise: what counts? Nursing Research, Vol. 1, September, pages 84-93.

20 February 1995

Memorandum by the Royal College of Midwives

The Royal College of Midwives welcomes this opportunity to comment on the position of research in the reformed National Health Service. Should there be an opportunity for us to give evidence in person, we will be pleased to do so. Our evidence looks at the wider aspects of research in the Health Service and in particular

7 March 1995]

[Continued

in the contribution which can be played by midwives who are the senior professional in attendance at 75 per cent of the births in this country.

1. The Royal College of Midwives broadly welcomes the principles of the NHS R&D strategy (Department of Health 1991) in particular the emphasis on interdisciplinary research, and the production and dissemination of evidence to guide practice by the Cochrane and York centres. The setting of priorities which recognise the shift in healthcare provision from hospital to the community is most appropriate. Midwives are actively engaged in aspects of the R&D programme at local, regional and national levels including the work of the York and Cochrane centres and with the research priority exercises.

2. We support the recommendations of the Department of Health Task Force (1993) which considered a strategy for research in nursing, midwifery and health visiting, and hope that these recommendations will be considered by the committee. As the major givers of care within the National Health Service it is vital that interventions by and the contributions of midwives and nurses are subjected to rigorous examination to ensure maximum effect and efficiency. Whilst we would like to support the broad principles of the evidence submitted to your committee by the RCN there are a number of important additional points we wish to make.

3. Points specific to midwifery include:

- (i) The provision of maternity has been and will continue to be greatly affected by the policy document, "Changing Childbirth" (Department of Health 1993). This document promotes the use of evidence-based practice. At the same time, however, some of the organisational changes proposed (and currently being put into practice at some speed) do not always arise from evidence. A lengthy research agenda has been generated by the implementation of the recommendations and the practice targets set out in this document. This includes questions about the best way in which to organise cost-effective care which fits women's needs, and also the means by which the needs of special groups of women (for example those from minority ethnic backgrounds, disabled women, or those who are ill or at high risk of complications), can best be addressed. This is an example of the necessity of an interdisciplinary approach to research, and also of an area where government policy has resulted in the need for urgent and widespread evaluation and assessment.
- (ii) In order to generate research which can be used to guide practice, input is needed from individuals who can offer a wide range of perspectives. These should include both practitioners and users of the service. Such an input is required at every stage of the research process; from framing and asking the initial question, to designing a sound and practical research design, dealing with problems in the study as they arise, and finally in developing recommendations for practice arising from the results.
- (iii) For research to be genuinely interdisciplinary, and for evidence to be moved effectively into practice, there is a need for more effective education and preparation of practitioners and researchers.
 - (a) Midwifery has at the moment no more than a handful of specially trained researchers, all of whom have had to develop their careers in serendipitous and unstructured ways. It is still very difficult to become a researcher in midwifery where the initial education, appropriate further training courses, and financial support are all lacking. This is being addressed at some levels; for example, the fast-developing midwifery degree programmes (both pre- and post-registration) will result in qualified midwives being more research-aware and should provide a basis for building a research career. Still needed, however, is a network of post-graduate training courses in research methods, from the basic level to Ph.D. standard, with appropriate financial support. It is difficult (though no longer impossible) for non-medically qualified staff to gain Medical Research Council research training fellowships, for example, and there are a small number of fellowships awarded from other sources, including the Department of Health. The lack of a coherent and supported development programme is hindering midwifery's ability to be supported by a critical mass of researchers who can adequately inform its knowledge base. The small number of well trained and highly motivated midwifery researchers need support and recognition if they are to be able to meet all the demands placed upon their time.
 - (b) Education of both midwifery students and practitioners in research awareness and critique is vital to assist in the application of appropriate research results in practice. To achieve this will require recognition of the need for good quality education in research at all levels from pre-registration courses through to continuing education programmes for practitioners. For this education to be effective and widespread, management support is needed to allow time for study and also recognition that financial support for good quality courses is necessary.
 - (c) The RCM broadly welcomes the changes recommended by the Culyer Report (Department of Health 1994) however, we were disappointed with its medical orientation whilst the wider aspect of health provision and health care including the contributions of midwives and nurses received scant mention.

4. General points include:

- (i) The Medical Research Council (MRC) must become more open to applicants for funding other than doctors. Multi-disciplinary studies led by non-medical practitioners should be given due

7 March 1995]

[Continued

consideration. The terms of reference of the MRC require review to encompass more than pure scientific and clinical research and board membership reviewed to ensure that members have the skills and knowledge to assess non-medical applications.

- (ii) We note with concern the proposed membership of the new National Forum to advise on R&D in the NHS. The absence of specific representation for midwifery and nursing (the major providers of care in the NHS) or indeed of any user groups does not inspire confidence.

The RCM which is actively engaged in a number of interdisciplinary projects, welcomes the encouragement of such developments within the wider R&D programme. However, the RCM is aware of the difficulties experienced by midwives in gaining access to high quality research education and training and in developing careers in research. We look forward to the recommendations of this committee in this regard.

9 March 1995

Examination of witnesses

PROFESSOR ALISON KITSON, Director of the National Institute for Nursing, Chief Officer for Research, RCN, DR SENG A BOND, Vice Chair of the RCN Research Advisory Group, Member of the RCN Research Committee, and PROFESSOR SALLY REDFERN, Member of the RCN Research Advisory Group, Director of the Nursing Research Unit at King's College London, representing the Royal College of Nursing, were called in and examined.

Chairman

1222. Good morning, Professor Kitson, Dr Bond and Professor Redfern.

(Professor Kitson) Thank you, my Lord Chairman. Could I start by introducing my colleagues?

1223. Please.

(Professor Kitson) I have with me Dr Senga Bond who is the Director of the Nursing Programme at the Centre for Health Service Research at Newcastle-upon-Tyne and who is also Vice Chair of the Research Advisory Group of the Royal College of Nursing and serves as a member of the Research Committee in the RCN, and also Professor Sally Redfern who is the Director of the King's College Nursing Research Unit and is also a member of the Royal College of Nursing Research Advisory Group. I would like to start by just summarising three which I think are very general, but very important points from the evidence that we provided you. The first is that in order to achieve the greatest impact in health care, we need to involve all health-care professionals in creating a knowledge-based evaluative culture and I think what we would welcome today is to be able to explain and expand the nursing contribution to that journey. Secondly, we believe that there is a real need for a solid research and development infrastructure to be set up for all the professionals both recognising the advances that have been made, but also mindful of the major pieces of work that still need to be done. Finally, on the basis of a shared understanding and a better infrastructure, we need to commit ourselves to a much stronger approach to looking at education and research careers in nursing and professions allied to medicine. Those would be the three key things we think are important.

1224. Please tell us what you mean by research in nursing and if you would give us some examples, perhaps relating to successful innovations in services which have arisen from nursing research and also indicating the places in the United Kingdom where some of these advances are taking place?

(Professor Kitson) I think, certainly mindful of the comments that Professor Jane Robinson has already

communicated to the panel where she identified that nursing research should not been solely as a clinical endeavour, whilst I agree with the spirit of that comment I actually feel that the essence of nursing research, as in medical research, has to have a very strong clinical and practice focus. I think given the nature of the problems that we try to solve within nursing research we must take a wider social, psychological and economic perspective in the way that we try to solve our problems. So nursing research is more often looking at quality of life issues, it is looking at the long-term support of those people who are chronically ill. It is also looking at adaptation and aiding recovery of people who have an illness. By the very nature of our investigations it has to take a broad approach. In substantiating the perspective that we take some work that has been conducted in the Cochrane Collaborating Centre recently by Dr Nicky Cullum has identified over 250 randomised control trials within nursing and most of the common themes have been around these areas of quality of life and providing support. She identified 57 cited RCTs looking at patient teaching, information giving and anxiety reducing strategies and then moving down to midwifery and care of the new born identified at 38 RCTs, nurse education looking at 35 and peri-operative care identified 18 RCTs. The more common areas that we would identify as nursing led innovations, pain management, critical care, incontinence, pressure sores and infection control, each of them have between four and eight randomised control trials. We would argue that the area of creating health gain and improved quality of life for patients is the area where nursing research would lead, and in some of the innovations where nursing research has actually improved patient experiences. I can cite a former colleague of mine, Dr David Thompson's work on cardiac rehabilitation where he again conducted a randomised control trial looking at the effectiveness of psychological support and counselling to people suffering myocardial infarction and again identified a significant improvement in the recovery and quality of life indicators. There are some very impressive and important pieces of work being done. I would suggest that they are probably what you would describe as

7 March 1995]

PROFESSOR ALISON KITSON, DR SENG A BOND
AND PROFESSOR SALLY REDFERN

[Continued]

[Chairman *contd.*]

health service research related to clinical interventions, but again because they focus in these areas we would expect to be involved. I have a number of other examples which I can leave with you. Finally, your question about centres of excellence in nursing research. Certainly Professor Redfern's department in the Department of Nursing Studies in King's College is seen as a centre of excellence, as is Dr Bond's centre in Newcastle. I would modestly claim that the National Institute for Nursing, of which I am a Director, is also seen by my peers and colleagues as aspiring to those dizzy heights as well. Finally, not to leave Baroness McFarlane out, the fourth which my colleagues have identified is the School of Nursing in the University of Manchester which is continuing to take the lead on community nursing initiatives.

Lord Perry of Walton

1225. In the Webb Report, the Task Force saw nursing research as a branch of health services research, embracing nursing practices, nursing services and their delivery, the nursing professions and workforces and their training and deployment, health promotion, and service systems involving nursing alongside other professions. That would embrace, in my view, health service research, some operational research, which is different in a sense, and this sort of support of the "R" element of SIFTR as part of a team doing that sort of thing. Do you agree with that as a general description of what nursing research is?

(*Professor Redfern*) Yes, I think we do. We would regard nursing research as clinical nursing research and research into nursing issues of which workforce issues would be an important part. We could cite some examples of research studies going on looking into just these things.

Baroness McFarlane of Llandaff

1226. We wonder if you could describe the current framework for the involvement of nurses in research and the support available to a nurse wishing to participate in research and the career path options.

(*Dr Bond*) There are four traditional routes by which nurses become involved in research. One is to go into an academic department of nursing and continue as a lecturer with an academic appointment continuing research at the same time as the clinical and teaching opportunities permit. The second is to work in a research unit funded by the Department of Health, funded by the Medical Research Council, or in the case of the Oxford Unit funded by a range of sources; there are many sources of funding. These typically are more short-term appointments but there exist a number of different kinds of units. The third method by which nurses tend to become involved with research is more recently NHS R&D posts. A number of NHS trusts are now creating R&D posts with some research component in them although "D" often prevails rather than "R". The fourth quite important means is that nurses often become involved in medical research projects. They may begin as data collectors but then become,

through various sources of training, researchers in their own right. There are a number of examples of nurses who have come into research through that route. None of them are without their problems at this time and I would like to elucidate on some of these if I may.

1227. I wonder about the lecturer position, the amount of training in research that is provided for that kind of post?

(*Dr Bond*) There has been a very rapid expansion of nursing in higher education, nursing departments which were formerly schools of nursing and midwifery have been absorbed into higher education, often in the new universities and before that into the traditional universities. It is easy to get an academic nursing appointment if you have a PhD. Nurses can practically walk into such appointments willy nilly without other research experience where traditionally for academic appointments one would have gone for the postdoctoral route, some publications, some good output, before being appointed to an academic post. What is happening, I think, is that nurses are being appointed too early in their careers to academic appointments, they are having to develop new teaching courses to suit regulations to produce good degree output and as a result the amount of research that they can engage in suffers profoundly. This is not a new problem but it is not one that has been assisted in any way by the rapid expansion of the higher education sector.

Chairman

1228. Would those PhDs be research based or would they be based on taught courses?

(*Dr Bond*) Typically they are research based. Occasionally some nurses will have done a masters preparation at the beginning of their research degrees—I did myself—but typically they follow the traditional research career of a three year PhD study and then there comes a hiatus without postdoctoral training which is absolutely crucial if you are going to develop first class investigators.

1229. We learned from your memorandum that the Department of Health support one post-doctoral fellowship in nursing research. Is that right? And three PhD studentships in nursing?

(*Dr Bond*) That is correct.

1230. Where do the other PhD studentship support funds come from?

(*Dr Bond*) There has been an increasing number of PhD studentships being appointed through the NHS R&D Strategy and certainly in our own region a number of PhD studentships and masters studentships have been made available through that route. Nurses can also apply for MRC studentships, but typically do not.

1231. Professor Robinson's memorandum said that nurse lecturers in the universities paid on the university lecturer scale are paid approximately 20 per cent less than the equivalent post for a nurse lecturer in an NHS College of Nursing. What is an NHS College of Nursing?

7 March 1995]

PROFESSOR ALISON KITSON, DR SENG A BOND
AND PROFESSOR SALLY REDFERN

[Continued]

[Chairman *contd.*]

(*Dr Bond*) This was the previous Schools of Nursing which have tended to take on college status prior to moving into higher education.

1232. I see, but virtually all are now within the higher education structure.

(*Dr Bond*) Or very soon will be.

Lord Perry of Walton

1233. I wanted to take up paragraph 3.10 in your document where you raise a whole lot of questions. There are half a million nurses compared to about 40,000 hospital doctors and I wondered whether you had any idea what proportion we are talking about of the half a million. For instance, how many graduates are there now coming out of the 29 higher education colleges or universities?

(*Professor Kitson*) If I can start, my Lord Chairman, on this one, I think the reason why we have asked the question is because, like you, we do not exactly know the answers, but again in preparing ourselves for the evidence, we have found out that there are now 30 institutions which are engaged in undergraduate preparation of nurses. We have also learned that there are approximately between 600 and 800 nurses in the United Kingdom who have PhDs, but, as Dr Bond reminded me, probably three-quarters of them are no longer practising research and are not involved in any sort of academic endeavour. If we take a model that we are beginning to explore, which is looking at the senior clinical posts within the Health Service which would be the nurse consultant, the clinical nurse specialist or the senior sister post, we would anticipate that there are about 20 per cent of the half a million nurses who would be at this grade and if we identified that grade as the grade that needed to be trained into clinical leadership, then we are beginning to get some sense of the proportion of nurses who would need to be trained at least to masters level as they are in North America, and then out of that 20 per cent, a proportion trained to PhD level who would follow, as our colleagues that we heard earlier said, who would follow clinical career paths in clinical research which would be nurse-led and nurse-led intervention, so I think the shocking reality is that there has been no substantial work done on these sorts of areas and, like you, I would dare to suggest that it needs to be done quite quickly so that we get some sense of how we are going to plan for the next ten years in delivering this evidence-based culture within the NHS.

1234. Could you tell me the sort of numbers in training in the 30 universities? What is the total?

(*Professor Kitson*) Again we will provide you with the exact figures in our written evidence, but off the top of my head I would expect that we are talking about between 2,000 and 2,500.

1235. Per annum?

(*Professor Kitson*) Per annum, with a much larger proportion being trained to diploma level still.

Lord Gregson

1236. Dr Bond said that nurses are not taking up MRC scholarships for PhD studentships. Could you explain why?

(*Dr Bond*) I think they see the competition as being stacked against them and that may or may not be a correct impression, and also a studentship on a PhD level from the MRC is on the student grant and nurses, when they have done their training, think that they ought to be employed on a staff nurse salary, so to revert to the student grant again is the same as any graduate---

1237. I do not know of any research student who does not think that.

(*Dr Bond*) But there is an issue then of investment in a research career and whether that career is subsequently valued by the profession, so there is a culture issue in nurses going through the PhD route and the financial sacrifices and whether it is worth making. If I may add to that, there has been a major expansion in special training fellowships jointly funded by the Medical Research Council and the NHS and this year there have been many more applications from nurses for post-doctoral research training which is very encouraging.

Chairman

1238. Do you believe that the same kind of arguments that you are posing about research would be likely to apply to midwives as well?

(*Dr Bond*) Yes, I think the same situation prevails in nursing, midwifery and health visiting.

1239. And health visiting too?

(*Dr Bond*) Yes.

1240. The expressed aims of the NHS R&D Strategy include the encouragement of research in nursing, and we would like to know what the Strategy has achieved so far; you assert that the subject areas defined by the Central Research and Development Committee tend to exclude the nursing contribution. Would you care to comment?

(*Professor Kitson*) My Lord Chairman, I will start by explaining the comment about the nursing contribution being excluded and perhaps I can start with an example. A medical colleague working in Oxford at the moment is involved in a large study looking at the development of a diagnostic tool for the identification of people with Alzheimer's disease and this particular project, which is funded by a pharmaceutical company, requires the patient suffering from Alzheimer's to be tracked and looked at until death, whereupon a post mortem is done. Now, the interesting scenario within the construction of the research study was that the interventions, the contact with the client was actually led by a team of nurses and as a researcher who is leading on a number of nursing interventions, I was thinking of all the wonderful descriptive data that we could get our hands on to look at the history of the disease, the social support networks, the coping mechanisms of the relatives and how we could actually interpret and understand the provision of that service, but because that had not been built into the actual financial predictions of the study, we were not able to

7 March 1995]

PROFESSOR ALISON KITSON, DR SENGU BOND
AND PROFESSOR SALLY REDFERN

[Continued]

[Chairman *contd.*]

undertake that. Perhaps that gives you a flavour of the sorts of way that we would wish to see a wider interpretation of some of the major pieces of scientific work that are being undertaken and how we can actually capitalise and collect the broader information that is needed to provide better health care.

Lord Flowers

1241. That comment would apply to charitable foundations as well as the pharmaceutical companies?

(*Professor Kitson*) Undoubtedly yes, and it is basically about trying to broaden the understanding of the nature of systematic investigation and I think Professor Peckham's reforms have actually enabled us to make these sorts of arguments more clearly.

1242. Is there any foundation which supports nursing research?

(*Professor Kitson*) A short response is no, but we are currently engaged in discussions both with Wellcome and the MRC to begin to open up this area.

Baroness Perry of Southwark

1243. I think, my Lord Chairman, also the Macmillan Fund.

(*Professor Kitson*) Macmillan have a history of supporting nursing.

1244. And nursing research.

(*Professor Kitson*) More traditionally nursing education, but increasingly nursing research as evidenced by the Centre for Palliative Care which like ourselves is a research unit that is fully funded by charity.

Chairman

1245. Is it not the case that the Sainsbury Trust gave support to the Nursing Development Unit in Oxford?

(*Professor Kitson*) They did, yes.

1246. There are possibilities of areas to which you might be able to apply for grants to interdigitate with the medical research projects to which you have referred?

(*Professor Kitson*) That is the case, but again as with most organisations they have quite rigid rules and certainly with an organisation like Sainsbury they are a pump priming organisation and do not support long-term research. Again, nursing tends to fall between stools because you will not be received in or you will not be considered if you do not have a credible research track record and the only way to get a credible track record is to get funding so we seem to be in this curious Catch 22 situation.

1247. The implications of your comments would be that you would have been happier if the medical colleague seeking to identify a marker for Alzheimer's disease had invited you to collaborate in the application in the first instance?

(*Professor Kitson*) In an ideal world that is what we would have wished for.

Baroness Perry of Southwark

1248. I was really interested in your Appendix two in which you talked about the problems of the low ratings in the research assessment for existing academic departments. You have talked about the reasons, the difficulties of performing research, but I wonder if there had been any steps taken to try to right that situation? Do you think that it will be righted in time for the next research assessment exercise?

(*Professor Redfern*) May I take that one, my Lord Chairman. Yes, it is true that the nursing departments in universities did not fare that well in the research assessment exercise. It was partly a function of the new universities with their new Departments of Nursing, many of which should not have entered into the 1992 exercise, they were too busy coping with mergers and the new nursing curricula and Project 2000 to even consider developing a research infrastructure and also they did not have, in many cases, a research base. Of the more established nursing departments three departments got a rating of four which were King's College in London, Manchester and Surrey, and two got a three, Edinburgh and Liverpool. The consequences of that exercise have been most constructive and it has focused some departments to develop their research strategy and it has exposed the lack of infrastructure, so many now are doing much more than they have done before and I think we can thank the exercise in some part for that. We are expecting the 1996 outcome to be better for certain departments, particularly those rated with a three or four last time, they are expecting to do better next time. The subject panels are to be set up in April of this year so there is a year to publish their criteria and to develop the procedure for that. There was not that period of preparation last time. One major point which I think is important to mention here is that the research assessment exercise is not a good indicator necessarily of research activity in nursing. There are many nursing units and centres which are either outside the research assessment exercise because they are not closely related to university departments, or are in the RAE but in other disciplines because there is no nursing department in that university, for example the Health Services Research Centre at Newcastle, the Sheffield Centre for Health and Related Research and the Centre for Health Economics at York, all of which have a lot of nursing research going into them. The ones that are totally outside the RAE are the National Institute of Nursing, the Centre for Cancer and Palliative Care, and the RCN Daphne Heald Research Unit. In many cases a lot of the best research, or a substantial amount of high quality research that is going on is going on in these centres and they either get lost to nursing in the assessment rating or do not actually get included. It is unknown at this stage whether the new RCN and the London School for Hygiene and Tropical Medicine Centre for Policy Research in Nursing, where that will stand in the next RAE. The

7 March 1995]

PROFESSOR ALISON KITSON, DR SENG A BOND
AND PROFESSOR SALLY REDFERN

[Continued]

[Baroness Perry of Southwark *contd.*]

RCN is not itself included in it and the London School of Hygiene does not have a department of nursing.

1249. It does of course take time, does it not, to build up the record of publications and writing of books and so on?

(*Professor Kitson*) Yes.

1250. The Departments which you described are relatively new as well, where people with brand new PhDs have to be planted straight into research work. These are going to take some years to build up, probably well beyond the next round?

(*Professor Redfern*) That is right. May I can add one point here, that there is a different kind of model to encourage and nurture nursing researchers within established multi-disciplinary disciplines at Sheffield whereby rather than developing Department of Nursing studies and appointing Clinical Nursing and Research Chairs into such a department, Clinical Nursing and Research Chairs are being appointed into established departments which have a multi-disciplinary base. The first one is in health care of elderly people where a nurse has just been appointed to that to join a clinical medical professor and a professor of social gerontology in the Department of Health Care of the Elderly in the Faculty of Medicine at Sheffield. The model there is to encourage nurse researchers as well as other multi-disciplinary disciplines within that Department and when the Trent College of Nursing is merged with Sheffield University and when the time is right then such a Nursing Department in that discipline might develop and these Clinical Nursing Chairs will move into that Department.

1251. What about the nursing practice research units, can you describe those for us?

(*Professor Kitson*) If I may start with my vision of what a nursing practice research unit is and describe those that are already in existence. Given the size of the nursing profession and the broad base upon which people come into it, both educationally and in terms of potential research ability, we believe that it is very important for our profession to be able to target good people and to be able to locate them in supportive environments where they will be hothoused or nurtured into becoming research leaders of the next generation. We also believe that it is very important to be able to demonstrate successful partnerships between clinical practice, education and research. We think that given earlier comments relating to the nursing contribution to health gain that there is a case for identifying nursing led programmes in areas traditionally that nurses have taken the lead, such as palliative care, looking at the management of distressing symptoms, the earlier work that we were discussing, rehabilitation and support and counselling of clients. We believe that if you have dedicating people and units to undertaking these programmes in partnership with other scientific units then we would be able to identify talented people coming through the research career, plus to identify and to develop people who can lead as principal investigators in some of the programmes that at the minute we are not able to mount because we do not have sufficient manpower to do it. I think

the units that are already set up that would lend themselves to this description would be the Community Nursing Professorial Units led by Professor Tony Butterworth in Manchester, which is a partnership between the local trust and Manchester University, the Centre for Cancer and Palliative Care Studies, which we have already identified, which is located in the Institute of Cancer Research at the Marsden and again has a mix of joint appointments between clinical practice and research, and our own unit in Oxford which is the National Institute for Nursing which again very much has grown from a partnership between clinical practice and scholarly work.

(*Dr Bond*) May I make an addition to that, my Lord Chairman. One of the issues is about the kind of research training opportunities available to nursing as they go through a nursing career. Typically, one has to leave clinical practice to engender research skills and it is very difficult then to re-enter clinical practice where research ideas are generated, but there is no equivalent to the research training a registrar gets in medicine and there is no legitimate time available in nurse career posts to develop research skills. As a consequence, one must always leave the profession to become a research worker and I think it is salutary that the three people here have no real clinical content in their work.

Chairman

1252. University-based nursing education and research have been largely funded by the NHS to date. The academic posts are in many instances funded by the Health Service and I take it that you are seeing the potential development of these nursing practice research units of various kinds through funding from the R&D budget of the NHS?

(*Professor Kitson*) My Lord Chairman, can I just reiterate the fact that only one of the centres we have identified is actually funded by NHS core funding. Both the Centre for Cancer and Palliative Care Studies and the National Institute of Nursing are not seen as legitimate targets for funding and I think this would be something that we would wish to raise in terms of infrastructure support and funding, and that if we are serious about providing educational and research opportunities to all professional groups, then we do have seriously to look at the infrastructure funding.

Lord Perry of Walton

1253. In paragraph 3.2 you said that nursing has not been part of the SIFTR arrangements, but in fact the Medical Research Council who gave us evidence quoted extra nurses as very definitely a part of the SIFTR provision in the concordat. Would you like to comment on that?

(*Dr Bond*) Yes, I would like to make one point on that. If I may allude to a particular project which the MRC have funded, that is the Oracle trial of antibiotics in pre-term labour, we know that some obstetric units refused to enter the trial because they did not have the nursing, ie, midwifery, staff with the time to enrol patients and so that trial was prejudiced

7 March 1995]

PROFESSOR ALISON KITSON, DR SENG A BOND
AND PROFESSOR SALLY REDFERN

[Continued]

[Lord Perry of Walton *contd.*]

on the one hand by trying to find the service costs to provide the antibiotics and on the other hand by trying to provide money to pay for nurses, ie, midwives, to recruit patients, so it is not a normal practice that the "R" in SIFTR finds its way into nursing budgets. Anyone who is trying to conduct nursing research in mostly teaching hospitals and seeks a portion of SIFTR to assist in the funding is given pretty short shrift.

(*Professor Kitson*) Could I add as well that the actual clinical teaching of the lecturers of nursing is not recognised and is not supported nor is the research element of academic posts which basically means that there is no infrastructure to support nursing research and clinical supervision within existing arrangements. We would certainly welcome the possibility of the relooking at it which has come from Culyer.

1254. I am far from disagreeing with what you say. I think the answer is that it ought to be part of SIFTR and the fact is that nobody knows what SIFTR is being spent on and nobody knows where it goes. It just disappears into the maw of hospital expenditures.

(*Dr Bond*) But, my Lord Chairman, if I may comment, SIFTR is based on the medical undergraduate numbers and basically medical undergraduate training and nursing training and nursing education in the higher education sector or otherwise has never been given an equivalent source of funding.

Lord Butterfield

1255. The first year I was in Cambridge the first tranche of SIFT went straight into the nursing budget there.

(*Professor Kitson*) By mistake?

1256. The NHS R&D directorate in the South and West region is funding research general practices which I do not think you included in your vision about nurse research units. What exactly are they up to and how would you see them being incorporated in your plans for the future?

(*Professor Kitson*) Well, if I can just say that I was discussing the evidence that the Royal College of General Practitioners provided and we got on to this area of practice units and discovered that what the general practitioners were advocating as a *locus* of support and development for research in general practice was very similar in ideology and in principle to the sorts of nursing practice research units that we were trying to set up. I think it is actually quite interesting because one of the messages that I have taken from the NHS reforms is that we have to think multi-disciplinary and we have to think in Health Service research terms, whereas what seems to be happening is that now that we have begun to realise what the disciplines' contributions to health gain and knowledge generation are, we can actually move back and say, "Well, we need to grow our own discipline and we need to develop our people in identifying the questions that need to be answered and in finding the solutions". Therefore, basically the orientation of both the general practitioners and nursing is to begin to look at the wide range of

research that we have to undertake, not just going for RCTs, but incorporating a range of methodologies in these units and beginning to look at how we can redress the problem that both of us have of training good research leaders to undertake the major programmes of work that need to be done. So I was really using that as a model and perhaps indicating that, like general practice, nursing is putting forward a case that this should be considered.

Chairman

1257. They did suggest the possibility that there might be supplementary funding, some of which is coming from their own College and elsewhere, to create research practices with the additional funding necessary to carry out that research, and some suggestion was also made by them that certain general practitioners might be funded to have research sessions for the performance of research. That is the kind of thing you have in mind as a possibility?

(*Professor Kitson*) Absolutely, yes, and indeed our own unit in Oxford has grown very much from a practice base and working with people almost at the inductive stage of hypotheses generation where you see what is happening before you can actually put it into the hypothesis testing phase.

Baroness McFarlane of Llandaff

1258. We gather that the Department of Health is currently examining research capacity in non-medical disciplines and we wondered what representations you have made and what steps you would like to see taken.

(*Professor Redfern*) May I take that one or start off and my colleagues will add to it. Certainly the Research and Development Department at the Department of Health is looking at research beyond medical disciplines alone and as to what steps the RCN have taken, I will leave my colleagues to respond to that because I am not aware that the Royal College of Nursing has actually yet taken any concrete steps, but we are aiming to consolidate strengths and we are targeting talented people and centres. We would argue very strongly for targeting talented people and centres rather than spreading any funds that there are too thinly and too widely. By doing that we would support the development of a critical mass of nurse researchers, to pick up a point made earlier, who have some kind of security of tenure and do not have to follow a research career by contract hopping which is very much the case at the moment. There is a need for nursing research to move into multi-centre collaborative studies and longitudinal studies attracting substantial funding from recognised research. A start has been made here, and I would quote the Newcastle Centre for Health Services Research, their work on outcomes, some of the work at the Nursing Research Unit at King's College on multi-triangular methods in measuring the quality of nursing care and the work there also on workforce issues following longitudinal designs.

7 March 1995]

PROFESSOR ALISON KITSON, DR SENG A BOND
AND PROFESSOR SALLY REDFERN

[Continued]

[Baroness McFarlane of Llandaff *contd.*]

(*Professor Kitson*) If I could just add that it is going back to the question that Lord Perry posed about the list of questions, how many nurses with certain training do we need? I would actually say that we do not know the answers to those questions in any sort of proper systematic and scientific way. I would therefore say that we actually need to look very seriously at what proportion of the nursing workforce we want to train as scientists, to train as people who can lead the nursing contribution to knowledge generation. I would also say that not only do we have to respond to the question of the number of scientists we need, we also have to get clear what sort of nurses we want to be in purchasing roles and in provider roles and in leading the profession. Certainly the whole role of the nurses within the purchasing team is one that we looked at very seriously in terms of their capacity to interpret the evidence based on a number of nursing led interventions, for example leg ulcers, pressure sores, and see how they can get them into the contracts. Again, I would suggest that none of this work has really been taken on in the manner that is required. I think that we have quite a big agenda in front of us to begin to get these answers.

Lord Perry of Walton

1259. It seems to me that you have got your proportions slightly out of kilter. You said to me that you thought 20 per cent of half a million nurses were needed in the research area. You are producing 2,500 a year with a basic degree and it would take 40 years to get 200,000. It seems to me that you are setting your targets too high too soon.

(*Professor Kitson*) Can I just qualify that. Out of this 20 per cent of the workforce with some sort of primary degree leading to a masters, out of that proportion it would be possibly five per cent of that proportion trained to postgraduate and postdoctoral level.

1260. I am not talking about that, I am talking about a first degree.

(*Professor Redfern*) I would agree that that is a realistic target we have to set. Comparing developments in North America and in Australia where it is now an all-graduate profession, and in Scandinavia.

(*Dr Bond*) A recent study done in North America from the Rand Corporation actually was able to correlate the improved recovery rates of people with myocardial infarcts with the level of qualified nurses working with patients. I would have to say that this is an area that needs much more rigorous analysis.

Lord Gregson

1261. I must say when you gave those figures I wondered whether you were including all the schools of nursing that are not yet included. What is the total if you include those, it must be more than 200,000? That is the real figure, is it not?

(*Dr Bond*) Substantially more. We could supply you with written evidence.

1262. That is the real figure we are talking about.

(*Dr Bond*) Yes, but the proportion of graduate nurses is a minority. Most nurses are still doing diplomas rather than graduate study.

Lord Butterfield

1263. I am very intrigued about what has been achieved in Australia, but I just wonder whether they have yet got to the level of all-graduate nurses that we all aspire to generally in Australia or whether it is only in the big centres. I do not know for how long graduation has been a central part of the preparation for their nurses.

(*Professor Kitson*) As far as I am aware, they made a decision between ten and 15 years ago and overnight all the colleges of nursing went into universities. They have been dealing with fall-out since, but I would say that technically they are graduates.

1264. So they are not SRNs, they are BAs?

(*Professor Kitson*) They are graduates, yes, and I would have to say again that one of the long-running discussions that certainly Baroness McFarlane since 1972 has been involved in is really do we want an all-graduate profession and what are the trade-offs and how do we actually prepare nurses to give good quality nursing care. All these things are linked and in a sense we are at one end of that spectrum of service delivery.

1265. I am sure, my Lord Chairman, we are all delighted to think that you are going to be recruiting people with, if I can put it bluntly, good A-levels rather than people who have no qualifications at all and it is very important that, among those, you identify your able people who can be your potential framers of hypotheses and leaders of research groups, but I wonder how we are going to help you accelerate the process.

(*Dr Bond*) I think the whole issue is about training opportunities and creating a culture in which to go into research in nursing is actually valued because at the moment there are training opportunities which are not being taken up. There are not many, but they are there, but we still have a very small number of nurses who are at the level of academic performance who are able to use the research training opportunities and the danger is trying to do too much too quickly and actually steadily improving the opportunities for the few nurses who have the capacity to benefit from serious research training. My concern with the Department of Health's strategy at the moment is that it will become more project-led and, therefore, my programme, which is due to finish in 20 months, sees no future and at my stage in my career to do, as Professor Redfern suggested, project hopping is not particularly comfortable.

Chairman] Well, thank you very much for coming to see us.

TUESDAY 14 MARCH 1995

Present:

Butterfield, L.
Flowers, L.
Gregson, L.

Perry of Walton, L.
Selborne, E.
Walton of Detchant, L.
(Chairman)

Memorandum by Professor Stephen Holgate, Associate R&D Director for the South and West Region**MEDICAL RESEARCH AND THE NHS REFORMS**

I was appointed to the position of part-time Research and Development Director in the Wessex Regional Health Authority in January 1993. During the two years that I have undertaken this task we have worked to implement the local and national NHS R&D agenda.

At a national level this has meant ensuring that researchers and the users of research findings have access to information with regard to consultation in arriving at R&D priorities and ensuring that information with regard to calls for proposals in specific fields is made available to those wishing to submit applications. Regular attendance at Professor Michael Peckham's Regional Research and Development Committee meetings has enabled us as R&D Directors to keep closely in contact with national activities and at the same time share each other's experiences with regard to the implementation of the programme. On the whole, this has been most successful and the rolling programme of R&D in specified fields, including health technology assessment, has produced relevant and high quality proposals which have been funded. This process has greatly catalysed the establishment of multiprofessional networks who on the whole have been more successful in obtaining support from the national programme in being able to provide the appropriate skill mixes.

At local level our remit was not only to be responsive to national NHS R&D incentives but also to be responsive to local needs. In a region such as Wessex this latter aspect was important because of the large geographical area to be covered and the disparate nature of the community interested in participating in the programme. Of particular relevance has been the real progress made by the "new Universities", Portsmouth and Bournemouth, to produce highly competitive proposals and attract considerable new support to their institutions. Each of these Universities have now appointed Research and Development Directors of their own to help plan their work at the interface between their academic activities, the NHS R&D programme and local purchasers and providers of health care. An absolutely key feature to the success of the R&D programme here in Wessex has been the establishment of networks, particularly in areas which previously had been underresourced, both in skill and in finance, for undertaking R&D. Thus we have established the Wessex Regional Network of Primary Health Care (WREN), a network for research in social services and complementary medicine and we are currently looking at establishing a network for community based psychiatry. One particular feature of the NHS R&D initiative has been the opportunity of establishing a "bottom up" approach, thereby involving quality researchers across the professions. In addition it has enabled us to work closely with those less familiar with research methodology, especially nurses and therapists, thereby allowing their more active involvement in the R&D agenda.

In order to administer both the national and local activity it was necessary to establish a Research and Development Committee. Although I chaired this, membership of the Committee was from across the Wessex Region and was constituted to contain individuals chosen on their research and personal qualities rather than being representational. It was, however, important to make sure that there was proper geographical representation on the Committee and also strong input from health professions allied to medicine, purchasers and providers. It might be thought that such a diverse membership would have detracted from the main agenda and from the quality of the R&D programme, but in fact, quite the reverse occurred. The diversity and richness of the R&D programme that resulted from the activities of our Regional R&D Committee was quite remarkable. To effect this agenda we established a Project Grant Committee that dealt both with commission and response mode research funding. Researchers wishing to apply for funding had initially to pass through an outline proposal phase and if this was successful a full proposal was sought which was subjected to high quality peer review. Commissioned or task orientated R&D stemmed not only from the prioritisation process being undertaken nationally but also locally. We established a series of Task Forces or Working Groups that comprised individuals from across the Region and that again were multiprofessional in their structure. Task Forces were convened in Mental Health Care, Primary Health Care, Health Promotion, Cancer and Cancer Services, Maternal and Child Health and HIV and Sexual Health. Great care was taken to use information, if it was available, obtained from national sources to avoid duplication of effort. The net result of these Task Forces was a series of research priorities from which we could make calls for proposals.

*14 March 1995]**[Continued]*

This turned out to be an extremely successful method of attracting high quality proposals in fields relevant to purchasers as well as the providers and users of research.

A third and important component of the Regional R&D initiative was training and education. It was very apparent that while medical practitioners were reasonably adept at undertaking R&D and, indeed, understanding and using the findings of R&D, health professionals allied to medicine largely lack these skills. Therefore, using the four Universities in Wessex we were able to convene a highly active and productive Training and Education Group and as a consequence generate training programmes which included PhD studentships, research fellowships, research support (coaching) schemes and methodological workshops. This activity has been very well received by the research community and has generated much good will and enthusiasm for engaging in the NHS R&D programme.

There has been some concern that the NHS R&D programme is developing separately from the biomolecular base. This, however, has turned out to be far from the case. In all four universities we have had a very strong response from those engaged in biomolecular science wishing to involve themselves in the development of their research findings and in particular to help to develop new methodology for assessing their effects and for measuring their outcome. The response mode funding has proved particularly attractive to researchers wishing to engage in this aspect.

The NHS R&D initiative during the first two years has produced great expectations. Enormous progress has been made over a short period of time and this has largely been the result of a willingness of the research community across all health professions who wish to engage in this activity. As R&D Director I have found it particularly valuable to adopt a bottom up approach taking into account local needs and skills as well as tilting the general direction of the R&D programme through national incentives. With the reorganisation of the NHS Executive the Wessex Region no longer exists and the R&D offices, as well as other functions, have been relocated to Bristol and the new South and West Region. This "centralisation" places the R&D programme in possible jeopardy. One of the major reasons for the rising success of the programme has been the local as well as the national programmes, and the ability of researchers and users of research to have a real feel for an activity that was going on in their midst. This has been made possible by the establishment of strong networking within and between health professionals and institutions. I hope that by centralising activity within a much larger geographical area, as a result of the NHS reforms, these important local contacts will not be threatened and the R&D programme not develop into another purely "centralised" activity. One thing that I have learnt in being R&D Director is that local identity with the programme is essential for its success and, indeed, this is what made the whole exercise so different from previous sponsoring of research within the United Kingdom. One possible way round the centralisation problem is to establish a series of Associate R&D Directors geographically placed and with sufficient resources and expertise to continue to strengthen and build upon the networks already established. Because of our particular geographical difficulties, this is the model we are working towards in the new South and West Region and is the reason why I wish to continue as Associate R&D Director, at least for the time being, to make sure that the transition period is passed through smoothly.

To conclude, the National Health Service Research and Development programme has been an outstanding success in Wessex and this is largely the consequence of Professor Michael Peckham's vision and enthusiasm. There has been an enormous response to produce high quality proposals in relevant areas of need and this has largely been possible through the establishment of local networks. Training and education is an extremely important component of the initiative and in any future activity should be considered as a major priority to continue to build the R&D capacity within and across the various professions. Specific emphasis should now be placed on building up R&D capacity within the primary health care setting and to encourage health professions allied in medicine to engage actively in the programme. The Culyer Report (*vide infra*) will help with this. Finally, it is essential that attention is given to career development in NHS R&D, at present this does not exist and will discourage those who wish to make their careers in this field.

SUPPORTING RESEARCH AND DEVELOPMENT IN THE NHS—THE CULYER REPORT

I was privileged to be a Member of the Culyer Committee and I am therefore familiar with the report and its intentions. In my opinion it provides an opportunity for research and development to be protected from the service market place and as such should enable R&D, which is currently being squeezed out of provider organisations, to be protected and strengthened. It is especially important that opportunities are given for research to develop in primary care settings and to be open to health care organisations other than teaching hospitals and yet at the same time preserve what is good in research in our schools of medicine and their support hospitals. For the first time the report will provide an opportunity for infrastructure funding for R&D to be directed towards those who most need it, i.e. those who are engaged in R&D activity rather than on the basis of student numbers or other criteria. It will also give an opportunity for strategic placement of funding and be the stimulus for both purchaser and provider organisations to obtain their own information about and strategically planning of their own NHS R&D programme rather than letting this occur haphazardly and in a non-accountable manner, as is currently the case.

*14 March 1995]**[Continued]*

In the implementation of the Culyer Report it will be important not to produce dramatic changes in funding over short periods of time but to try and move smoothly into a new way of operating as has proved so successful in the special area Health Authority review that took place in London. Linking the assessment exercise of large institutions to the HEFCE assessment would be a great advantage and would hopefully avoid duplication of effort.

The Culyer Report will also provide the necessary infrastructure to support clinical trial work within the NHS and would enable some sort of prioritising exercise to be undertaken in determining the types of trial for which the NHS can provide a test bed. The appointment of a National Director for Clinical Trials would help this in a manner similar to the way that health technology assessment is being implemented by the Standing Group on HTA under Professor Miles Irving's chairmanship.

Devolving responsibility for the provision of health care to the local level and creating a competitive marketplace is having the effect of fragmenting the provision of services for special issue groups in whom research is particularly important. Great care will have to be taken to correct this as a component of implementation of the Culyer recommendations.

CHALLENGES AND OPPORTUNITIES FOR UK MEDICAL RESEARCH

While the UK research and development programme is now proceeding apace and appears to be answering some important questions raised by those who purchase and provide health care as well as the patients who are the beneficiaries of this, one particular concern that I have is the connection of the programme with the more basic biomolecular developments and the science base generally. While the concordat with the MRC (and other research councils) has worked to a degree I would like to see much more evidence of a smoother working relationship between the MRC and the Department of Health in this particular field with a view to helping develop discoveries from the science base into practice. The United Kingdom has an extremely strong science base and it is my belief that further advantage could be taken to bring discoveries more rapidly and more effectively into the development phase to produce an increase in both health and wealth of the nation. This could be greatly encouraged if stronger partnerships could be established with the private (industrial) sector rather than the research councils, the Department of Health and the industrial sector working on separate agendas. The formation of an overarching national liaison group (as recommended in the Culyer report) should certainly help this. However, it is my belief that more effort is needed to integrate these three organisations in an equal fashion as stakeholders in the R&D agenda and in the improvement of health and creation of wealth. Possibly these changes will occur as a result of the Science and Technology Foresight Programme.

A second important issue is that of career development in the field of NHS R&D. Now that the R&D activity is firmly embedded within the new Health Service it is extremely important that attention is given to career development and to producing highly competent professionals who are able to service this new agenda. Involvement of professional organisations such as the Royal Colleges in professional and continuing education and support of those researchers who are non-medical are essential features of developing the R&D capacity in the UK. However, while it is important that an evaluative culture is spread throughout the new NHS it will be important to produce major foci of strength so as not to dilute and duplicate effort.

Memorandum by Professor Sir Miles Irving, MD, FRCS

INTRODUCTION

I welcome the opportunity of giving evidence to the Sub-Committee. I do so in two capacities. Firstly as a Professor of Surgery at Manchester University and Honorary Consultant Surgeon at Hope Hospital, Salford, and secondly as Director (part-time) of the NHS Health Technology Programme for the Research and Development Directorate. Prior to this latter appointment I was Regional Director of Research and Development for the North Western Regional Health Authority.

These appointments enable me to comment from the points of view of a clinician practising in one the most deprived areas of the United Kingdom, an academic, and someone deeply involved in, and committed to, the R&D programme.

I wish to emphasise that my responses represent my personal view of the R&D programme and the NHS reforms and are not the official view of the Research & Development Directorate.

RESPONSE TO CALL FOR EVIDENCE

You have given three questions to be answered and I have responded to them in the order given. I have not commented on all the topics mentioned, but have confined my remarks to those where I feel I have a contribution to make.

14 March 1995]

[Continued

1 WHAT IS MY ASSESSMENT OF THE R&D STRATEGY?

The report of the House of Lords Committee in 1988 was a perceptive statement of some of the difficulties besetting the NHS at that time and an accurate reflection of the problems the NHS research programme, as then established, was having in addressing these difficulties. By recommending the establishment of the R&D initiative the House of Lords set in train a radical process which slowly but surely is leading to a change of culture amongst clinicians and other Health Service staff. The acceptance of an evaluative approach to medicine is now clearly apparent amongst a substantial number of my colleagues as they realise not only the intellectual credibility of such an approach, but also its vital necessity where there is a limited budget and a burgeoning programme of new technologies which need evaluation. This change in attitude has to be fostered and sustained if we are to have any hope of instituting evidence based medical practise and coping with the explosion of new technologies breaking out around our heads and threatening to overwhelm us.

The public, press, politicians and the professions are now increasingly accepting that the way to gain extra resources is not by always increasing the budget allocation, but by practising efficiently on the basis of scientific evidence of what is effective. By this means ineffective or outmoded treatments can be eliminated and new treatments evaluated before they are introduced. Government will probably be more sympathetic to calls for additional resources to finance well substantiated, cost effective, and proven new techniques when we can be seen to have eliminated inefficient and ineffective practise.

Since its inception in 1991 the R&D initiative has moved ahead in a formidable fashion. The change in attitudes described above has allowed the development of a wide ranging programme which has prioritised NHS research needs and set about commissioning reviews and primary research in these areas of uncertainty.

The success of the programme so far is attributable primarily to the vision and industry of Professor Michael Peckham, the Director of Research and Development, and the team that he has built around him. The quality and enthusiasm of the civil servants who have supported this programme has, with few exceptions (now remedied), been of the highest calibre. The vision and critical enthusiasm of my fellow Regional Directors has been awe inspiring and together they have made progress to a degree which I would not have thought possible in a programme which began such a relatively short time ago.

As a practising surgeon with a continuous commitment to, and involvement in, clinical research and the advancement of medical techniques this is the first time in the 35 years I have been in medical practise that I have seen a sustained research programme that truly is relevant to everyday clinical practise and addresses the day to day problems of technology transfer across the whole spectrum of the NHS, not just in the teaching hospitals. If we build upon the opportunities presented to us we will have the possibility of using the whole NHS as a test bed for the thorough and rapid assessment of existing and new technologies.

Had the programme been up and running five years ago I believe that many of the problems of the transfer of new technologies, such as we recently have witnessed associated with laparoscopic surgery, would have been avoided.

The current R&D programme, if allowed to develop further will significantly affect the management and outcome of our patients. However, the R&D process and its future development are still at a vulnerable stage and it is important that the initiative is not damaged by the shortsightedness of Trusts or reactionary responses by biomedical researchers or the Universities. Having for the past 15 years had an MRC funded Research Unit associated with my department I do not need reminding of the importance of fundamental biomedical research, but my clinical practise makes me realise that the transfer of technology from bench to bedside is a difficult and uncertain process. For me to find that treatments, proved and demonstrated in our MRC research unit, are still not being instituted in a neighbouring intensive care unit 12 years after the date of their publication shows the need for an additional research component to that generated in laboratories.

Of course basic biomedical research must be sustained and developed as appropriate, but the gains currently being made by HSR must not be sacrificed to support such research. Basic and Health Services research are not in competition with each other, they are complimentary and without each other neither will be effective.

(1A) CRITICISMS OF THE R&D INITIATIVE

(1a(i)) *Communication*

The above supportive comments about the R&D programme do not mean that I am entirely without criticism of the initiative so far. It has been my experience that when the initiative is explained to those to whom it is relevant they see the logic and value of it and support its aims. Unfortunately, despite a major effort by all involved the message has not as yet reached many of those for whom it is intended. Whilst there has been a relatively successful communications strategy at regional level, as evidenced by the publication "Bandolier" from the Oxford RHA, the same cannot be said to be the case at national level. This is a significant failing which has impeded growth of support for the initiative. The problem is now being addressed, but a great deal of work needs yet to be done and there is an urgent need for a co-ordinated national communications system to disseminate the philosophy and the results of R&D.

14 March 1995]

[Continued

1a(ii) *Co-ordination of the Programme*

It is perhaps a positive sign that enthusiasm for the initiative has led to a veritable explosion in the number of research projects and reviews emanating from HSR Centres. Unfortunately, these sometimes address the same topics. The problems associated with duplication can be formidable and it is essential that wasteful, and almost certainly confusing, duplication of effort is avoided by co-ordination between regions, and between regions and the centre.

1B SPECIFIC POINTS

I now move on to comment on some of the specific points raised in your call for evidence.

1b(i) *Centrally Commissioned Programme (CCP)*

The advantage of the CCP is that issues of major concern to the NHS are prioritised and acted upon centrally. Topics can be funded centrally or distributed to the regions, the MRC and other funding bodies. Central co-ordination and commissioning of the programmes appears to be working well, but the relatively small number of staff supporting this activity are under enormous pressure from what are very large programmes of work.

1b(ii) *Regional Research Programme*

The changed Regional Research Programmes directed by the newly appointed Regional Directors of Research & Development commenced prior to the re-organisation announced in *Managing the New NHS* (July 1994) and they were the catalysts of interest in R&D. As Regional Directors and their teams spread the message of the initiative and its evaluative approach to health care purchasers and providers alike, the latter saw the potential benefits and logic of the new approach and expectations were raised. By and large the restructuring of the regional programmes to meet the new requirements was supported by the medical academic community but there remained some who doubted the feasibility and credibility of Health Services Research.

The re-organisation of the Regional Research Committees led to a new approach in responsive funding compared with that practised under LORS. It was interesting to witness the enthusiasm of many of the more progressive medical academics as they saw the relevance of HSR and supported the new projects.

The developing structure showed signs of working well only to be faced with the re-organisation described in *Managing the New NHS*. Despite the fact that under the new system there is now a full time Director, I have concerns the something valuable may have been lost. In disseminating the philosophy of the evaluative approach to medical practise I am convinced of the importance of the messenger as well as the message and of the need for "street credibility" in the Regional Director of R&D. The sort of opinions and values that need expressing at the present time to essentially conservative professions will, in my view, only be accepted from those who also are obviously at the sharp end of the delivery of the Health Service. I fear that these qualities may be reduced or even lost with a full time Director, even though I appreciate that the demands of such a post in the new expanded regions requires a greater commitment from the Regional Director of R&D.

1b(iii) *Health Technology Assessment*

Obviously I have a particular interest in this area. I have been most impressed by the enthusiasm which has been evident from those involved with this aspect of the R&D programme. It has evoked enormous interest and support because the topics it addresses are easily understood and seen by all to be relevant to their practise. My concern is that with so much to do and a relatively small research community to do it, research worker overload and with it failure fully to deliver the programme is a potential problem. Having raised expectations in this area it is vitally important that the R&D Programme is given the resources to deliver the results.

1b(iv) *Cochrane and York Centres*

I do not have any major comments on these aspects of the programme, other than to say that they are essential components of the exercise and that at present they appear to be fulfilling their function. The real test of their effectiveness will be in dissemination and implementation and they appear well on the way to addressing these aspects.

*14 March 1995]**[Continued]*

1C ADVICE TO DIRECTOR

I think the major challenge to the Director and his team is to ensure that they do not lose sight of the strategy for this programme of change by becoming involved in the details of the programme. The Director has to ensure that the R&D philosophy permeates the new structures associated with purchasing and the internal market. Whilst I do not believe that purchasing and Trust status as such pose major problems for the programme, I am concerned that competition between Trusts could inhibit the development of Health Services Research. Although the Culyer recommendations will do much to overcome this by allocating the R element of SIFT(R) according to relevant research endeavour, there are still challenges to be met. The Programme Director has to ensure he addresses the major issues and not to become absorbed in the minutiae of the programme itself.

2 THE CULYER REPORT

I think this report brings a breath of fresh air and rationality into the problems associated with the funding of research relevant to the NHS. One of the great advantages of this report is that it helps us focus on the strategy necessary for the delivery of the programme. Some of the comments on the report, such as those already given to your Committee and reported in the press, imply that the implementation of Culyer will seriously damage existing research programmes particularly in teaching hospitals. Such criticism is patently misconceived. The NHS funded research programme constitutes but a small part of the overall budget for medical research in this country. Your Committee in its 1988 report commented that the NHS funded research at that time did not address the needs of the NHS. The changes recommended by Culyer are those necessary to redirect the NHS funded segment of the overall research budget. Without such a change in direction the deficiencies identified in the 1988 report will not be addressed. Our Universities and teaching hospitals can still undertake basic research funded by the other major grant awarding bodies and will have only themselves to blame if they do not rise to the additional opportunities presented by the NHS programme as envisaged by Culyer.

The challenge of Culyer will be to produce changes, such as providing service support for high quality clinical and basic research, without damaging what is excellent in the current system. Culyer's recommendations must not, however, be used as an argument for maintaining the status quo.

2a TERTIARY REFERRALS

I am pleased that this has been identified by your Committee as an area for comment for it addresses problems that are being generated by the reforms. There are two aspects to tertiary referrals to centres of excellence.

Tertiary referral is obviously necessary for some patients who have conditions which, because of their critical nature, can only be managed in centres where the necessary expertise and facilities are concentrated. One would hope that such centres would have associated active research programmes. On the other hand, there has been a tradition of making tertiary referrals to teaching hospitals of cases whose condition is interesting rather than critical. Such patients are investigated in the current fashion more for the convenience of the research workers than for the patient's benefit. The changing environment of health care means that research should follow such patients rather than the reverse. The challenge to the research community is to devise methods for the investigation of such patients in the hospitals near to where they live. Not only will this be cheaper for purchasers and more convenient for patients, it will stimulate the research environment in the hospitals concerned. Clinical research must, in the future, be organised in the way patients are managed.

The problem at the present time is that because of confusion between these two categories of tertiary referral patients the former group are suffering and there is now clear evidence of patients who need tertiary referral for the management of complex conditions not being referred to the appropriate centres.

(3) *Additional Challenges*

I do indeed identify additional challenges not currently being addressed by the NHS programme, Culyer or the Technology Foresight exercise. I wish to comment on one particular area which is causing me considerable concern.

The social environment in which medicine is practised is of considerable importance to its outcome. I believe that the success of much of the R&D programme will depend upon it addressing major challenges to its effectiveness currently arising from social changes in our community as well as the more obvious topics that it is currently investigating. It has long been recognised that adverse social factors influence physical and mental health. In many areas of our country, such as those in Salford and Manchester long recognised as being deprived, there is an obvious social deterioration in certain sections of the society. Working as I do in one of the six most deprived areas of the UK as defined in the Black report, I am increasingly aware of a subculture characterised by poor standards of education, social isolation and breakdown of family structure.

14 March 1995]

[Continued

The consequences of the development of this subculture are violence, drug abuse and appalling vandalism, including repeated damage to health centres, schools, and even the hospitals built to serve these communities. A widening gap between these socially deprived individuals and the remainder of the population is opening with an apparent increasing inability of the one side to understand the other.

Such impressions are difficult to quantify but I can clearly identify one statistic. In the first 32 years of medical practise as a surgeon, working in the city centres of England's five biggest cities, I saw only four firearm injuries. Indeed, for the first 15 years of my time in Salford I did not see one. Over the last five years I have witnessed a steadily rising number such that in the last year 20 patients were admitted to Hope Hospital, Salford, with injury caused by firearms. This is but one quantifiable aspect of a multi-faceted problem.

I believe that the impact and benefits that should flow from both evidence based medicine and high technology medicine will be dwarfed by the effect upon the equanimity of society of the activities within this subculture. The effect of fear on the health of people increasingly aged and living alone is unknown. The management of patients with fear and other adverse consequences of the development of this subculture is not something that I see being addressed by the R&D programme. Study is necessary to find the causes of this societal breakdown and the methods of dealing with it. Without such knowledge I fear that much of the effort being put into the R&D programme will be to no avail as we concentrate time and effort in dealing with the consequences of the breakdown of society.

Professor Sir Miles Irving
Director of NHS Health Technology Programme
Professor of Surgery, University of Manchester
Honorary Consultant Surgeon, Hope Hospital, Salford

Memorandum by the Department of Health

Further Questions to the Department of Health: 9 February 1995

Question 1. *Please provide notes on (a) the Leeds Clearing House (b) The Oxford Centre for Evidence-Based Medicine (c) the Research Project Register*

(a) UK OUTCOMES CLEARING HOUSE ON HEALTH OUTCOMES

1. The UK Clearing House for Health Outcomes was set up late in 1992 and is funded by the UK Health Departments.
2. The UK Clearing House provides an information and advisory service based on a reference database of existing information about health outcomes.
3. The Outcomes Clearing House has established a database comprising some 600 items, covering outcomes assessment projects. These cover assessments of clinical outcomes related to particular topics and interventions and generic work on the development of outcomes assessment tools and methodologies, e.g. the "SF36" health status questionnaire.
4. Its purpose is to act as a resource for the NHS, providing information and advice on outcomes assessment and relevant methodologies. It updates and expands the information database and responds to queries from the NHS. Four bulletins have been produced and several publications are in hand. It also runs workshops, and is providing support to develop a range of topic-specific outcome indicators.
5. The Clearing House receives funding from central sources totalling £156,000 per annum. Its costs equate to this plus a small amount earned from activities which are charged for.
6. The work of the Clearing House is monitored by an Advisory Group, which includes representatives from each of the Departments involved in funding it (Dept of Health, Scottish Office, Welsh Office and DHSS Northern Ireland). Reports from the Clearing House are evaluated before each tranche of funding is released.

(b) THE OXFORD CENTRE FOR EVIDENCE BASED MEDICINE

7. The Centre for Evidence-Based Medicine, with offices at the John Radcliffe Hospital, is a joint venture of Anglia and Oxford RHA, the NHS R&D programme, the Nuffield Department of Medicine of the University of Oxford, the Oxford-Radcliffe Hospitals Trust, and the Oxford Institute of Health Sciences. The Centre will be opened in March 1995.
8. The aim of the Centre is to promote clinical practice based on information derived from patient-based, population-based, and laboratory research. The Centre will promote training for clinicians to continuously evaluate their performance.

14 March 1995]

[Continued

9. The Centre will concentrate on clinical medicine but will encourage the development of Clinical Epidemiology.

10. The budget for the Centre is £150K per annum.

(c) NHS R&D PROJECT REGISTERS SYSTEM

11. A NHS R&D Project Registers System (PRS) was established in 1993. The purpose is to avoid gaps and unnecessary duplication in applied health research being supported by the NHS and the other funding bodies. The PRS is necessary for planning, managing and co-ordinating programmes of R&D. The System makes it possible to monitor the use of funds and provides the basis for accountability for NHS R&D. The PRS is part of the NHS R&D Information Systems Strategy and is based on a co-ordinated network of personal computer-based project registers.

12. The objective of the NHS R&D Project Registers System (PRS) is to provide:

- a tool to support efficient research management, by identifying unproductive duplication of research projects;
- a decision-support for those commissioning new research or using existing research;
- a basis for accounting for expenditure on research; and
- an input to research overviews.

13. The PRS records information, at individual project level, about R&D projects funded by the Department and the NHS. Links to enable information exchange with major external funders of relevant R&D (elsewhere in government, the Medical Research Council, UK charities and industry, and to a limited extent overseas) will be developed. A "pilot" link with the MRC has been developed.

14. The broad categories of projects on the PRS include:

- (a) Regional office funded projects;
- (b) RDD funded projects;
- (c) DH/NHS Executive funded projects not under RDD's management;
- (d) projects taking place in the NHS not under the management of the regional office;
- (e) projects funded by the other health departments; and
- (f) projects which make no call upon NHS resources but which nevertheless are of interest to the NHS (for instance some entirely university-based research).

15. The PRS presently holds details of 3,000 R&D projects.

16. The database is available through Regional R&D Directorates; options are being examined for making it more widely available.

17. Consideration is being given as to how the PRS should develop to meet future information requirements identified in the report "Supporting R&D in the NHS" (the Culyer report).

Question 2. *You are aware that evidence has reached the Committee to suggest that the internal market is adversely affecting the flow of patients to specialist centres, on which some researchers depend. In this context please tell us exactly what constitutes (a) a tertiary referral and (b) an extra-contractual referral; and in each case who initiates a referral and who pays for it.*

(a) Tertiary Extra Contractual Referrals (ECRs)

18. A tertiary ECR is defined as a referral made by a medically qualified Consultant to another medically qualified Consultant outside an existing contract.

Move to a notification system

19. Prior to April 1993 authorisation for elective tertiary referrals had to be sought from the purchaser. In April 1993 further guidance was issued in Health Service Guidance (HSG) (93) 8. This introduced a system whereby providers were no longer required to obtain authorisation from the purchaser prior to accepting for treatment patients referred as tertiary ECRs. Instead, providers need to notify the purchaser that the referral has been made and give details of the cost involved. This arrangement applies only to tertiary ECRs made from one NHS provider to another.

20. The operation of this "notification system", particularly of the payments system, is currently under review. Purchasers are expected to meet these costs, in the same way as for emergency ECRs. The notification system operates using a two part form. The first part is completed by the referring clinician and one copy is sent to the receiving unit/clinicians and one copy is sent to the purchaser. The receiving unit then has three

14 March 1995]

[Continued

weeks to complete part two of the form and send it to the purchaser otherwise it will be expected to meet the cost of the treatment itself. Resolution of the problem of failure of referring units to initiate the process by completing part one of the form is being resolved by making the referring unit responsible for the cost of treatment when there is failure to complete the form. Timely information on the cost of treatment is vital for purchasers if they are to effectively manage their ECR budgets.

(b) *Extra Contractual Referrals*

21. The vast majority of referrals made by GPs are covered by contracts between purchasers and providers. However, GPs remain free to refer patients in line with their clinical judgement and will sometimes wish to refer a patient to a hospital or service with which the DHA for non-fundholders and procedures outside the fundholding scheme has no contract in place. Such referrals are known as extra contractual referrals (ECRs). Guidance on ECRs has been issued under the cover of EL (92)60 which is currently contained in consolidated ECR guidance FDL (93)07.

22. Expenditure on ECRs accounts for approximately two per cent of total expenditure by purchasers.

Payment of ECRs

23. DHAs hold funds to meet the cost of expected levels of these ECRs, though as DHAs will never have infinite resources it will not be possible for all patients to be treated immediately. DHAs need to manage the timing of the commitment of their funds for ECRs.

Emergency ECRs

24. In an emergency, GPs need to be able to make the referral they judge best in the confidence that the patient will be treated promptly and the cost met by the DHA. The NHS Executive has issued clear instructions to ensure that emergencies are always treated as such and any discussion concerning payment occurs *after* the patient has been treated.

Elective ECRs

25. In non-urgent cases, DHAs will be expected to fund treatment as quickly as available resources allow, according to the clinical priority of each case. In these cases the circumstances in which a GP's choice of service provider can be questioned are very limited and any decision to do so will not be taken lightly:

- every case will be considered on its own clinical merit, based on all of the available facts;
- it is expected that the referral will be discussed with both the provider and the referring GP before any decision is made.

26. The grounds on which an ECR can be refused are very limited. The only acceptable grounds for refusal are:

- where the patient is not the purchaser's responsibility, i.e. the patient is not a district resident or the patient is the responsibility of a GP fundholder for the treatment planned;
- where prior authorisation for the ECR was not sought where it was medically reasonable to expect the provider to have done so;
- the referral is not justified on clinical grounds. In making such judgements the DHA would be expected to ensure that it takes appropriate clinical advice;
- an alternative referral would be equally efficacious for the patient, taking account of the patient's wishes.

27. A "national" policy on whether and/or when to approve ECRs would not be appropriate, as DHAs are in the best position to take into account "local" needs and priorities.

28. DHAs are expected to keep their ECRs under review, with the aim of establishing contracts, where appropriate.

29. The Government recognises the importance of specialist care centres and the NHSME undertook a major review of contracting for specialised services in liaison with providers, purchasers, regions and the JCC. The review sought to develop contracting arrangements which, reflected the need for and nature of the service, allow for economy of transaction costs, take account of the new developments and avoid purchasers and providers suffering uncertain or unpredictable fluctuations in volumes and cost.

30. Guidance was issued to all District Health Authorities: an EL(93)98—Contracting for Specialised Services and an accompanying booklet containing appropriate contracting models based on existing good practice. The Government firmly believes that this guidance will ensure that these particular services continue to provide a valuable and essential service to the NHS.

*14 March 1995]**[Continued]*

31. It was recognised that different models would be appropriate in the context of local circumstances, however, EL(93)98 contained an action note which requires Regional Health Authorities to ensure that:

- (1) appropriate arrangements are in place for purchasing specialised services.
- (2) the model adopted for these services is jointly agreed between purchasers and the specialised unit.

32. The booklet, entitled "Contracting for Specialised Services—a practical guide", described the common features of specialised services which are often characterised as high cost/low volume services provided for a disparate catchment population. It describes a number of different models including "regionwide purchasing" "consortia contracts" and "co-ordinated contracts": where no existing arrangement were in place purchasers are encouraged to use the "lead purchasing approach" to contracting for specialised services. The booklet has been well received in the service and arrangements are being made for it to be reissued.

Question 3. Please explain the organisation and funding of postgraduate and vocational training for medical specialties, and the role of Postgraduate Deans. Will the abolition of the regions affect the position?

33. The present structure of postgraduate and continuing medical and dental education (PGCMDE) is based on the unnumbered working paper "Working for Patients: Postgraduate and Continuing Medical and Dental Education" issued by the NHS Executive in April 1991. This set out the central role of the postgraduate dean and established protected budgets for postgraduate and continuing medical education respectively.

34. In partnership with the medical Royal Colleges, the postgraduate dean is responsible for ensuring a high standard PGCMDE in his region (or part-region since April 1994). He is the budget-holder for the direct costs of postgraduate training and education (i.e., of doctors in training grades) including study leave, courses and the costs of postgraduate medical centres in hospitals. The postgraduate dean is normally under joint contract to the University and RHA. He is at the centre of a supporting network of educationalists comprising, for hospital doctors, clinical tutors, who operate at unit level, and for general practice, regional advisers in general practice, GP clinical tutors, course organisers and trainers. The budget for GP vocational training is normally delegated to the regional adviser in general practice. The postgraduate dean normally chairs the regional training committee.

35. The postgraduate dean is not responsible for the training costs of consultants and other career-grade doctors. The budget for continuing medical education is held by the Trust Chief Executive, as advised by the clinical tutor.

36. Since April 1993, the postgraduate dean has also been responsible for half the basic salary costs of all doctors in training (100 per cent of costs for flexible trainees) to ensure that training arrangements are not unduly jeopardised by decisions based on short-term service considerations.

37. The Medical Royal Colleges are responsible for setting the standards of training in their particular specialties. They operate a regional network which to some extent mirrors that of the postgraduate dean with regional advisers and specialty tutors at unit level.

38. The Government is currently implementing the recommendations of the Calman Report on specialist training which include the replacement of the registrar and senior registrar grades by a single unified higher training grade ("specialist registrar") and the award of a certificate of completion of specialist training by the GMC on the advice of the Royal Colleges to mark the end-point of specialist training.

39. The postgraduate dean will continue to have a key role both in implementing the Calman Report and in the new management structure for postgraduate medical education following the abolition of regional health authorities in April 1996. Discussions are still taking place with the Committee of Postgraduate Medical Deans but it is envisaged that at least one dean and regional adviser in general practice in each region will be located within the new regional offices of the NHS Executive under split contract arrangements with the University and the Executive. The dean will be accountable for his budgetary and management responsibilities to the Regional Director. The arrangements for the employment of the dean's support staff are still under consideration.

Question 4. Please tell us about (a) the special group on primary care research priorities following the Tomlinson report, announced in February 1994, and (b) the current investigation of research capacity in non-medical disciplines.

(a) Primary Health Care Research Priorities

40. Following publication of the Tomlinson Report and "Making London Better", Professor Peckham asked Professor Andrew Haines, Regional Director of Research and Development (DRD) for North East Thames Region, to chair a group to consider the research implications of the proposed changes in primary care in London. The work of this group was a special initiative taken forward within the Centrally Commissioned Programme (CCP) with the aim of collaborative funding with the King's Fund and the

14 March 1995]

[Continued

Nuffield Provincial Hospitals Trust. The group submitted its report in August 1993 and recommended a number of areas as priorities for research. The group's recommendations were considered within RDD and taken forward with the London Implementation Group as the main customer.

41. A meeting was held in November 1993 to seek the views of "field" customers from RHAs, HAs and FHSAs on the priorities identified by Professor Haines' group, broadly:

- staff development and skill mix;
- development of evaluation criteria and "tool kits";
- needs of special population groups;
- primary/secondary care interface in London;
- localities and constituencies.

42. The Department organised a major open competitive tender exercise early in 1994 which resulted in the receipt of over 300 outline research proposals. The selection process included two meetings, in April and July 1994, chaired by Professor John Howie of the University of Edinburgh, with representatives from HAs, the King's Fund, the Nuffield Provincial Hospitals Trust and LIG, plus a number of external advisors. Four agreed criteria were applied—scientific quality, policy relevance and applicability, feasibility, and academic service link.

43. It was agreed that the Department should, through the CCP, commission a variety of proposals which between them covered several of the priorities previously identified by Professor Haines' group. A number of projects have since been commissioned or are in planning, covering:

- outcomes based evaluation of a nursing-led intermediate care unit;
- evaluation of specialist outreach clinics in primary care;
- ethnic minority communities knowledge of, and needs for, health advocacy services;
- improving the supply of NHS dentistry in Inner London;
- pathways into care for the adult mentally ill from various ethnic communities;
- hospital at home schemes and evaluation of such schemes in London.

(b) *Research Capacity in the Non-Medical Disciplines*

44. The issue of research capacity in the non-medical disciplines has been covered in a separate written reply which stated:

1. Capacity in applied health research is being supported through the 13 Department of Health funded research units. Five year contracts will be let in the Spring of 1995. This provides 5 year funding for core staff with the possibility of reapplication.
2. In June 1995 the first Department of Health R&D Centre will open—the National Primary Health Care R&D Centre based in the University of Manchester. Substantial funding is being allocated to create a multidisciplinary health services research centre with core support for 10 years.
3. Currently three Nursing Research Studentships and a Post-Doctoral Nursing Fellowship are awarded annually through a Nursing Research Fellowship Scheme supported by the Department of Health.
4. The Research and Development Division's support currently covers the costs of 8 MSc Studentships in Health Economics at the University of York per year. These are administered through the Economic and Social Research Council.
5. In 1992 a Taskforce on the Strategy for Research in Nursing, Midwifery and Health Visiting was established to consider the implications of the NHS R&D Strategy for the nursing professions. The report was launched by the Minister for Health in May 1993. A copy of the report together with a summary of the annexes of the Taskforce working groups have been forwarded separately to the Committee. The Taskforce report was welcomed as relevant by the professions allied to medicine, notably the College of Occupational Therapists, the Chartered Society of Physiotherapy and the College of Speech and Language Therapists. The Therapy Professions' Research Group was convened in September 1993 at the request of the Department of Health to consider the implications of the Nursing Report for the therapy professions. A copy of the Group's report has also been separately forwarded.
6. A human resources strategy for NHS R&D will be launched in the summer of 1995. It concerns five main groups: career researchers; managers of research programmes; supervisors of research; practitioners skilled in critical appraisal, and the managers of health and social care who have responsibilities for using the findings of research to ensure high quality patient care services.

14 March 1995]

[Continued

7. In developing the strategy seven studies have been commissioned:
 - i. a review of the gaps in research skills identified in submissions to the Central Research and Development Committee (CRDC);
 - ii. a survey of applications submitted by NHS staff for Research Training Awards;
 - iii. a survey of the support for research education and training currently being provided within the NHS;
 - iv. a study of career profiles of health and social care researchers;
 - v. a survey of opinion leaders in R&D on the obstacles and strengths of the current situation;
 - vi. a discussion paper on the supervision of research;
 - vii. a discussion paper on the management of research.
8. Currently Regional Directors of R&D are funding 150 Fellowships. The intention is to build on and co-ordinate these initiatives in taking forward a national strategy for research training within the NHS R&D Programme.

Question 5. *Please supply copies of (a) the Calman report and (b) the Kendell report (three copies of each)*

(a) THE CALMAN REPORT

45. Three copies of the Calman report (Hospital Doctors: Training for the Future) published by the Department in April 1993 are attached.

(b) THE KENDELL REPORT

46. Three copies of the Kendell report (Report of the Working Party on the Review of the Consultants' Distinction Awards Scheme) published by the Department in October 1994 are attached.

Question 6. *The Culyer report (paragraph 3.3) recommended that purchasers should "have influence" over the size of the R&D levy. How is this influence envisaged? Will it amount to a veto?*

47. Purchasers will not have a veto. In assessing the amounts to be levied however the NHS Executive Board (NHSEB) will need to bear in mind that any level of levy agreed has to be set against the background of the Public Expenditure Survey (PES). The Director of Research and Development advises the Secretary of State through the NHSEB on the levy necessary to fulfil the tasks and obligations of NHS R&D. The Director of Research and Development as sponsoring director for the levy will establish a mechanism to monitor the R&D levy, purchasers together with other interests will be involved.

Question 7. *What are the rules governing the publication of results of clinical research conducted in NHS settings and (a) commissioned by the Department of Health or (b) paid for by pharmaceutical companies? The Agreement between the NHS and Great Ormond Street Hospital Trust dated 19 September 1994 and supplied to us by Dr Malcolm Green provides (paragraph 15) "The Trust's Director of R&D will have formal oversight of all communications . . . of the findings or interpretation of Research undertaken as part of the R&D programme before they are disseminated". According to Dr Green, such a provision is impractical, inappropriate and not feasible. Is it, nonetheless, normal and expected to be carried out literally?*

(a) COMMISSIONED BY THE DEPARTMENT OF HEALTH

48. The Department's centrally commissioned research programme is designed to provide information for the formation and evaluation of policy. Much of the supported work does not constitute clinical research in the NHS. The current contract clauses on publication read:

- "12.1 The research programme of the Department is open, subject to paragraphs 8 (Right to Data) and 12, and details of research are normally published.
- 12.2 Any publications of research material or of the results of research (as described in sub-paragraph 1 above) or of matters arising from such material or results is subject to the prior consent of the Secretary of State, which consent shall not be unreasonably withheld. Such consent may be given either unconditionally or subject to conditions, in which case any publication shall be subject thereto.
- 12.3 When a consent to publication is sought from the Secretary of State under sub-paragraph 2 above one draft copy of the proposed publication shall be sent to him at least 28 days before the date intended for submission for publication, so that he may advise the Researcher as to matters pertaining to Crown copyright, royalties and confidentiality. After publication the Researcher shall supply 10 copies of the publication, free of charge, to the Secretary of State.

14 March 1995]

[Continued

49. The Department gave an undertaking on 30 May 1989 that approval to publish would only be withheld in exceptional circumstances. A copy of this letter is *attached* as annex A. In practice the Department has not withheld permission to publish for any work covered by this contract. Publication and dissemination is encouraged and the Department supports dissemination activities at the end of most projects.

(b) THE PHARMACEUTICAL COMPANIES

50. The rules governing the publication of results of clinical research conducted in NHS settings paid for by pharmaceutical companies are those agreed contractually between the researcher and the individual company.

(c) GREAT ORMOND STREET HOSPITAL TRUST

51. The Agreement between the Secretary of State for Health, acting through the NHS Executive and Great Ormond Street Hospital for Children NHS Trust, which is identical to that agreed by all the SHA/Trust Hospitals, is designed to support research and development. The Agreement's paragraph 15(1) states, "The Trust's Director of Research and Development will have formal oversight of all communications, both written and oral, of the findings or interpretation of Research undertaken as part of the R&D Programme before they are disseminated". This paragraph was an agreed revision following a meeting with Chief Executives of the SHA/Trusts and their Directors of Research and Development at which the penultimate draft of the Agreement was discussed.

52. The purpose of the paragraph is to lay on the Trust the obligation to consider matters of potential medical importance and/or public health sensitivity, and to bring them to the attention of the Secretary of State before they are disseminated. This obviates the need for the Trust to provide notice and copies of forthcoming publications arising from centrally funded NHS R&D at least 28 days prior to publication to allow the NHS Executive to consider matters pertaining to Crown Copyright, royalties and confidentiality, which would be in keeping with current contract clauses given in the answer 7(a) above. Furthermore the wording "formal oversight" within paragraph 15(1) of the Agreement allows the Directors of Research and Development discretion in the extent to which the detail of any communication to be disseminated is examined.

Question 8. *Please supply examples of calls for research proposals arising from the priority areas identified by CRDC and SGHT.*

53. Examples of calls for research proposals in the NHS R&D programmes of health technology assessment, the interface between primary and secondary care, mental health and cancer are *attached* as annex B to this evidence.

ANNEX A

Letter from Mr J H Barnes, Director of Research Management, Department of Health and Social Security to Dr G Draper, Childhood Cancer Research Group, Radcliffe Infirmary, Oxford

DEPARTMENT OF HEALTH RESEARCH CONTRACTS—CROWN COPYRIGHT

I apologise for not writing to you formally before now about your research contract with the Department. I saw the outstanding correspondence between Oxford University and ourselves immediately I took up post; and I knew that the contract was causing concern to you and to colleague unit directors. Therefore, rather than simply continuing established lines of correspondence, I wanted to read through the recent course of events myself, and consider the best way forward. We have had a number of discussions in the interim; and I write to record the formal position reached.

The Department's arrangements for research obviously depend for their credibility and success on mutual confidence between all concerned. In that respect, the first point to make is that it is the Secretary of State's intention that research commissioned by the Department of Health should result in publication, whatever the research might show—thereby contributing to the general understanding. The clauses in our standard conditions should be read with that in mind.

At the same time it is not possible to change the terms of paragraph 7 of our standard conditions for research contracts, nor to modify its effect through the means of a covering letter. The paragraph implements those powers and responsibilities which have been delegated to the Secretary of State by the Controller of HMSO, in relation to Crown Copyright. Those powers cannot simply be set aside.

However, it is important to bear the following in mind when considering how those powers are to be used. First, they are intended to be used in such a way as to achieve the objects for which the particular research was commissioned (these will have been agreed by us as objectives for the particular project at the point of commissioning). Second, it is also necessary for the integrity and protection of Crown ownership in the

*14 March 1995]**[Continued]*

research to be assured. This obviously requires the exercise of judgement to ensure among other things that confidentiality is preserved as described in paragraph 1 of the standard conditions, and also that the publication per se does not expose the Crown to risk of legal suit or bring the Crown into disrepute. The Department has made clear that in reaching decisions on these matters, the facts brought to light by the research would not of themselves be grounds for withholding consent to publication. Where appropriate royalties or proper charges will need to be paid in respect of published material.

Thirdly, as the contractual provisions make explicit, those powers will be exercised in a particular way. Consent to publication, the reasons for any refusal or exceptionally the reasons for delay will be given within 28 days; in this latter case a new timetable for decision will be set in discussion with the researcher. Consent to a publication will not be unreasonably withheld; and I can assure you that in the event of an application for consent to publication being refused, the reasons for a refusal will be given so that the researcher might reconsider the proposed text in the light of perceived objections. And to repeat: the Secretary of State is committed to encourage the dissemination of scientifically sound research material. Lastly in this respect, I am sure that you are aware that there is a general expectation that Government behaves reasonably in the exercise of its powers, and can be subjected to legal challenge if it is thought to have behaved unreasonably.

We discussed the position on jointly funded research. The position in this respect is that if another party is contributing more than half of the funding to any project or unit, then the Secretary of State is permitted to concede copyright to the other party—provided the Crown is given access to, and is able to use, the research on favourable terms (which will be contractually agreed before commencement of the research). The Department's decision on any such matter is necessarily taken case by case.

30 May 1989

TENDERS

NHS RESEARCH AND DEVELOPMENT PROGRAMME

Call for outline proposals in health technology assessment

Health Technology Assessment (assessment of the costs, effectiveness and broader impact of any method used by health professionals to promote health, prevent, diagnose or treat disease, or improve rehabilitation and long-term care) is the centrepiece of the NHS R&D Programme. The NHS Standing Group on Health Technology has recently identified an initial series of priority areas for assessment, and the NHS Director of Research and Development now wishes to commission work in the following areas:

- Effectiveness and cost-effectiveness of alternative organisational models of stroke rehabilitation and associated interventions.
- Near patient testing in the hospital environment, to evaluate the effectiveness and cost effectiveness of near patient testing in comparison with rapid transit and conventional transit of specimens to a centralised laboratory service.
- Counselling in general practice; to evaluate the effectiveness, costs and benefits of counselling in primary care.
- Total hip replacement: to review the effectiveness and cost-effectiveness of different hip prostheses, with particular reference to variation in the outcome of total hip replacement.
- Long-term outcomes of drug use in asthma: to assess the long-term risks and benefits of the early introduction of inhaled steroids.
- Routine referral for x-ray of patients presenting to GPs with low back pain: to evaluate the effectiveness and cost-effectiveness of this approach in the management of low back pain.
- Comparative effectiveness and cost-effectiveness of established and new treatments for menorrhagia.
- Effectiveness and cost-effectiveness of paramedic training and pre-hospital management protocols in trauma and emergency care.
- Antenatal screening for HIV: to assess the feasibility, costs and benefits of screening pregnant women for HIV in areas of high prevalence.
- Screening for Down's syndrome: evaluation of the complementary use of ultrasound and biochemical methods including the development of methodologies for quantitative comparison of screening methods and programmes.
- The role of magnetic resonance imaging (MRI) in the district general hospital (DGH): to identify the effectiveness and cost-effectiveness of different levels of MRI sophistication in the DGH.

Short outline proposals in the above areas are invited, to be submitted on an application form available with supporting information on the underlying research questions, from:

*14 March 1995]**[Continued*

HTA Programme Secretariat, Research & Development Directorate, NHS Executive, Department of Health, Room GW52, Quarry House, Quarry Hill, Leeds LS2 7UE.

Outline proposals should be submitted no later than 15th July 1994, Shortlisted applicants will be notified by mid-September 1994, and invited to develop detailed proposals. The proposers of successful detailed projects will be notified by early December 1994.

Preference will be given to proposals which are designed to produce results generalisable across the NHS.

Research proposals for further priority areas in health technology assessment will be invited in due course.

Lancet 19 February 1994

NHS RESEARCH AND DEVELOPMENT PROGRAMME

Call for outline proposals for research into the interface between primary and secondary care

A recent NHS R&D review has focused on areas of need for R&D relating to the primary and secondary care interface. The Director of Research and Development for North East Thames RHA has responsibility for commissioning and managing the programme of R&D on the primary and secondary care interface on behalf of the NHS Management Executive. The Directorate now wishes to commission work in the following areas:

- Transfer of information across the interface between health care professionals and other agencies.
- Evaluation of clinical guidelines at the Interface.
- Appropriate access, use and location of diagnostic facilities and new technologies.
- Impact of purchasing arrangements on the interface.
- Aftercare: rehabilitation and community care for priority groups.
- Models of intermediate care.
- Patients and carers social needs.
- Implications of day case surgery.
- Characteristics of primary health care team and access to specialist care.
- Effectiveness of inpatient discharge procedures.
- Relationships of patterns of referral to health need.
- Impact on referrals and discharge of involving patients and carers in decision making.
- Appropriateness of outpatient follow-up.
- Evaluation of treatment by referral versus management in primary care.
- Prescribing across the interface.
- The changing skills and training requirements at the interface.
- Evaluation of specialist outreach schemes.
- Evaluation of shared care schemes.
- Implications of shorter length of hospital stay.
- Availability and patterns of secondary care services affecting entry.
- Evaluation of first contact care provided outside general practice.

Short outline proposals in the above areas are invited, to be submitted on an application form available, together with supporting information on the underlying research questions, from the Research and Development Directorate, North East Thames RHA, 40 Eastbourne Terrace, London W2 3QR. Outline proposals should be submitted no later than 22 April 1994. Short-listed applicants will be notified by mid-June 1994 and invited to develop detailed proposals. The proposers of successful detailed projects will be notified by mid-August 1994. If the response is larger than anticipated the process of considering funding may need to be staggered in which case applicants will be notified of any changes to the above timescale.

Preference will be given to innovative and multidisciplinary proposals which clearly identify a process for implementing research findings within the NHS.

*14 March 1995]**[Continued]**Lancet 20 June 1992***NHS R&D STRATEGY***Call for outline proposals in mental health*

As part of the NHS R&D strategy launched in 1991, reviews are being conducted of NHS needs for R&D in a range of key areas. A review has been completed of needs for R&D relating to mental health, and the Director of Research and Development now wishes to commission work in the following areas:

- community care of the severely mentally ill;
- quality of residential care for the elderly mentally ill;
- training packages for use with those working in primary care and the community;
- mental health of the NHS workforce;
- methods of establishing the mental health needs of a population.

Those interested in working in these areas should contact Monika Temple in the Research and Development Division of the Department of Health (Room 1236, State House, High Holborn, London WC1R 4SX; telephone 0171-972 3954; fax 0171-972 3972) for further details about the areas and application procedures.

The deadline for outline proposals is 15 July. Those asked to prepare detailed proposals will need to submit these by the end of August.

Further work will be commissioned by the NHS in due course in mental health and in other key areas. Preference in this first call will be given to those able to start work before December and to projects designed to deliver useful findings quickly.

SOUTH & WEST REGIONAL HEALTH AUTHORITY**NHS RESEARCH AND DEVELOPMENT PROGRAMME****CALL FOR OUTLINE PROPOSALS FOR RESEARCH IN CANCER**

The NHS R&D programme aims to ensure that the National Health Service has available, and uses, research based knowledge in its every-day business. The NHS Central Research and Development Committee advises on research priorities. The committee has recently endorsed a review by a CRDC advisory group on NHS research priorities on cancer. The Director of R&D for South & West RHA—having responsibility for commissioning and managing the programme of R&D in this area on behalf of the NHS Executive—now wishes to commission work on the following priority areas:

- Ways of effecting, maintaining and evaluating behavioural changes leading to a reduction in smoking at all ages, particularly children.
- The organisation and evaluation of services, including medical, psychosocial, counselling and other services, to meet the needs of those found to be at high risk of cancer due to a genetic susceptibility.
- Factors influencing delayed presentation by patients (e.g. psychosocial) and variations in onward referrals by physicians to oncology specialists.
- Factors influencing the accrual of patients into cancer trials (including why clinicians are reluctant to enter patients into national multi-centre trials).
- Studies designed to explain variations in disease outcomes, particularly in relation to variations in patterns of practice.
- Comparison of care for common cancers (e.g. lung, breast, colorectal) in specialist and non-specialist treatment settings with respect to psychosocial and clinical outcomes; and the relative costs of managing each step of disease progression.
- The clinical utility of second-line chemotherapy in advanced common cancers, particularly its comparison to best supportive care.
- Effective ways of helping health professionals break bad news, elicit concerns and respond to patients and relatives for their best psychological adjustment.
- Optimal management strategies for unrelieved symptoms, including pain and non-pain, in cancer patients.
- The most appropriate and cost effective model of service delivery and level of provision of palliative care services, including the role of Nurse Practitioners in hospitals and the community, and for improving the care of patients dying in acute hospitals.
- The early natural history of cancers that may particularly lend themselves to screening to reduce mortality (e.g. prostate, oral and skin cancers).

14 March 1995]

[Continued

- Methods for managing the introduction of innovative therapies in a cost-effective way.
- The roles of adjuvant, neo-adjuvant and combined modality treatments for primarily common cancers.
- Cancer treatment of the elderly including clinical outcomes and cost effectiveness.
- What prevents terminally ill patients from dying at home, if they so wish, and how can General Practitioners and their teams access information to help them care more effectively for their patients at home?

Proposals for projects that have a clear and practical outcome for health services and that have an emphasis on effectiveness, cost effectiveness and acceptability are particularly welcome.

Short outline proposals in the above areas are invited, to be submitted on an application form available with supporting information on the underlying research questions, from Cancer Programme Manager, Research & Development Directorate, South & West Regional Health Authority, Canynge Hall, Whiteladies Road, Bristol BS8 2PR. Tel: 0272 287 258. Fax: 0272 287 204. E-Mail: helen.ashworth@bris.ac.uk

Outline proposals must be received before 5 pm on 21 November 1994. Shortlisted applicants will be notified by early February 1995 and invited to develop detailed proposals. The proposers of successful detailed projects will be notified by the end of May 1995.

Research proposals for further priority areas in cancer will be invited in due course.

Further questions to the Department of Health

1: *What is the funding basis of the Hospital for Tropical Diseases?*

The Hospital for Tropical Diseases is a constituent part of the University College London Hospitals NHS Trust. The hospital is located in the grounds of St. Pancras Hospital and consists of:

- outpatient clinics
- an inpatient facilities for thirty patients
- a department for clinical parasitology
- same day appointments for emergencies
- the Hospital or Tropical Diseases Travel Clinic

The hospital's income comes entirely from normal service contracts: a combination of block contracts, extra contractual referrals and contracts with GP fundholders.

2: *What are (a) JPAC (Joint Planning Advisory Committee) and (b) MMAC (Medical Manpower Advisory Committee)?*

(a) JPAC (Joint Planning Advisory Committee)

The Joint Planning Advisory Committee was set up, at the request of the then Secretary of State for Social Services, at the end of 1985, following discussions between the Health Departments (England and Wales), the Joint Consultants Committee (JCC), the Committee of Vice-Chancellors and Principals of the Universities of the UK (CVCP), and the Medical Research Council (MRC).

The Committee's membership was drawn from the NHS, central and regional committees of the medical and dental professions, the Royal Colleges and Faculties, and academic and research interests. Secretariat support has been provided by the Department of Health, but the Chairman of the Committee has always been independent, though usually with an NHS background.

JPAC has been responsible for advising DH and the Welsh Office on the numbers of senior registrars and career registrars needed in every hospital medical and dental specialty, taking into account the needs of academic and research medicine, so as to provide an adequate supply of appropriately trained candidates for likely future consultant opportunities in those specialties. This is in line with the Secretary of State for Health's continuing priority to plan and provide for an adequate and affordable supply of appropriately trained doctors.¹

However, changes in the NHS over the last few years, and more recently the decision by DH Ministers to accept the recommendations of the Chief Medical Officer's Working Group on Specialist Medical Training,² and implement a new unified training grade (UTG) for higher specialist trainees, have meant that JPAC's methodology is no longer appropriate, not least because the new grade will broadly replace existing senior

¹ Aims, Goals, Priorities and Key Challenges, 1994-95 to 1997-98 (Department of Health)

² Hospital Doctors: Training For The Future, The Report of the Working Group on Specialist Medical Training (Department of Health, April 1993)

14 March 1995]

[Continued]

and career registrar structures. In parallel with this, it had been recognised that existing medical and dental advisory machinery had developed in an incremental way, resulting in overlapping committee structures and responsibilities. This led to the setting up of a single body covering all workforce issues—the Advisory Group on Medical and Dental Education, Training and Staffing (AGMETS).

AGMETS will oversee, among other things, workforce planning for the UTG. However, the day-to-day work of examining specialties to establish the numbers of trainees needed, which had been the responsibility of JPAC, will now be carried out by a sub-group of AGMETS, called the Specialist Workforce Advisory Group. This Group has similar membership to JPAC, although with greater NHS representation, and will ultimately have an independent Chairman.

The activities of JPAC were suspended in March 1994 to allow work to concentrate on developing both the new committee structure and the methodology for calculating trainee numbers in the UTG. However, in order to maintain the necessary controls on trainee numbers during the interim, the quotas set as a result of JPAC's recommendations have remained in force.

The first meeting of the Specialist Workforce Advisory Group, under the acting Chairmanship of the NHS Executive's Medical Director, took place on 16 February 1995, although the agenda necessarily concentrated on initial "housekeeping" issues, such as agreeing terms of reference, etc. It is hoped that the next meeting, scheduled for mid-April, will begin the task of developing the principles of the new methodology.

The current Chairman of JPAC, Professor Peter Gilroy Bevan CBE, resigned from his position in January 1995 and it is expected that, now the Specialist Workforce Advisory Group is up and running, JPAC itself will be formally wound up later this year.

(b) MMAC (Medical Manpower Advisory Committee)?

The Medical Workforce Standing Advisory Committee (formerly the Medical Manpower Standing Advisory Committee, (MMSAC) is an expert committee, set up to advise the Secretary of State on the future demand for and supply of doctors and medical student intake. The Committee will shortly be submitting its second report to the Secretary of State.

The Chairman, Professor Sir Colin Campbell, sent written evidence to the Select Committee on 24 January 1995.

3: We understand that central support for the excess costs of the ex-SHAs will be reduced to nothing by 1997–98. What will happen to the other element of central support, for clinical services necessary to sustain approved R&D? Will it continue? And will it become a charge on the new single funding stream for R&D? (DH evidence on p5 of HL Paper 12-I refers).

The Government is committed to bringing the SHAs into a national system for funding and supporting R&D. As soon as practicable SHAs will receive funds from the R&D budget for NHS R&D, service support and research facilities, in the same way as, for example, teaching hospitals. In parallel with this introduction into the new research funding mechanisms, the present central support for clinical services necessary to sustain approved R&D will cease.

However, we cannot yet be specific about how and over what timescale these changes can be made. The current central support will not map directly onto the Culyer system. The scope of service support and research facilities have to be defined, and many issues of principle and detail will need to be resolved, including how to continue to support any activities previously supported centrally but which are not appropriate either to the patient care market or to the R&D budget. This work is part of the process of implementing Culyer.

We intend to publish in April a plan for implementing Culyer which will clarify the issues and set a framework and timetable for addressing them.

4: What is the place of Operational Research (as defined in the attached note, and as distinct from health services research) in the NHS?

The scope of the NHS R&D programme was set out in "Research for Health"³. It is a multidisciplinary programme which places emphasis on the evaluation of the quality, effectiveness and cost of methods of disease prevention and treatment, and on research into the delivery and content of health care. An integrated approach between R&D funded directly by the NHS and biomedical research within and outside the NHS is crucial. Appendix F of the Culyer report sets out the agreed criteria that R&D funded directly by the NHS is expected to meet, i.e. it must be:

- relevant to the NHS
- protocol-based
- peer reviewed

³ "Research for Health", DH September 1991.

14 March 1995]

[Continued

- intended for publication
- generalisable, i.e. of value to decision makers outside the specific locations in which the work is undertaken

Some work satisfying these criteria will fall within the definition of operational research put forward by the Committee in its 1988 report and further developed in the Note accompanying the present question. The priority setting and co-ordination mechanisms in the NHS R&D programme attempt to identify important problems faced by decision makers in the NHS and to ensure that these are addressed by research whose findings will be of value to all those in the service facing these problems. One of the key aims of the R&D strategy is to avoid unnecessary duplication of work.

Those responsible for the operation of the NHS also face problems which call for investigatory work of a different nature. The term Operational Research (OR) is now generally used to describe analytical work with a strong quantitative slant which is largely client driven and which seeks to provide support to management decision-making (and OR is therefore commonly also known as "management science"). OR practitioners often work alongside professionals from other disciplines, such as statisticians and economists. OR tends to be relatively short-term and to provide rapid solutions to pressing problems. OR can feed into R&D (by raising questions which can best be answered through formal R&D studies) and OR often encourages the use of existing research-based information.

Within the DH, specific examples of OR include waiting time policy modelling, development of weighted capitation formulae and analysis of trends and shifts in health care. In the NHS examples include computer modelling to support the achievement of health targets, analysis to assist the deployment and scheduling of resources (such as staff, beds, operating theatres and outpatient departments) within hospitals and behavioural simulations to develop managers skills in contracting for health care. As well as such assistance to formulating and implementing policies and programmes, OR practitioners are also involved in evaluating them, helping investigate for example the effects of information technology on hospital performance.

Within the NHS Executive, explicit recognition has been given to the need to improve analytical capability in the NHS. "The NHS Executive will work towards improving both the quality of analysis and the general availability of analytical skills among employees."⁴ The Executive has been discussing with a number of university operational research/management science departments and health service management centres the development of postgraduate training courses in health operational research/management science. As a result of these discussions two such postgraduate courses will begin taking students (both new graduates and those already employed in the NHS) in the Autumn of 1995. The courses will receive pump-priming support from the Executive for the first two years.

Further Memorandum by the Department of Health

DEPARTMENT OF HEALTH ORAL EVIDENCE SESSION: 7TH FEBRUARY

WRITTEN EVIDENCE

Question 10:

According to the CVCP (p87), one of the purposes of SIFTR is to ensure "that clinical research and biomedical science research is possible in all medical schools, in order that doctors shall be educated in a proper environment". Are they right? Does the NHS accept that a proper environment for medical education must include research? If so, how is the research time of NHS consultants and honorary consultants being protected against managerial pressure to increase the work rate and the increased demands of teaching?

Written reply:

The Department is committed to the view that medical practice should be based upon the results of research and that doctors should get an understanding of research during their medical education.

The research carried out by consultants is an important component of the educational environment. At present, the Service Increment for Teaching and Research (SIFTR) is provided as a means of meeting *all* the various excess costs of undergraduate medical education and research. Deployment of SIFTR funds is secured by means of contracts to which universities are signatories.

A number of measures are taken (over and above financial protection via SIFTR). These include:

- the widespread promulgation of the "10 Key Principles" identified by the Steering Group on Undergraduate Medical and Dental Education and Research (SGUMDER) in its second report (attached). In particular:

⁴ "Managing the New NHS".

14 March 1995]

[Continued

- the first key principle which states that future doctors and dentists should be educated in an atmosphere which combines high professional standards (set by the General Medical Council and the General Dental Council) with a spirit of intellectual enquiry and innovation based on active research and development programmes;
- the eighth key principle which stipulates that in their plans, the universities and the NHS should take into account the implications of research for teaching and service provision, and should foster both the application of current research and the development of high quality new projects;
- the effective, periodic formal monitoring supervised by the Joint Medical Advisory Committee of the Higher Education Funding Councils. Two formal rounds of monitoring have been carried out since the passage of the 1990 NHS and Community Care Act and a third is currently underway. Such monitoring has not so far suggested that research activity linked to medical education is being undermined.

Question 14:

The Culyer report recommends that the clinical researchers applying for project grants should first obtain approval from the NHS provider concerned. The AMRC tell us that there is no need to restrict calls on NHS service support in this way: "Given that funds spread widely have been gathered together, there should be ample to deal with the proper service needs of projects coming through the research councils and the charities". Are they right?

Written reply:

The new arrangements for supporting research and development in the NHS will give better access to funding for service support. But this does not address the important point made in the Culyer report about the NHS giving active and considered support to worthwhile R&D.

If we want NHS Trusts to be positive supporters of the R&D they need to know that:

- the R&D is properly funded and not using hospital resources without agreement;
- it is worthwhile R&D;
- the service support and facilities it uses are properly funded and not diverting money meant for patient care;
- it is not creating service expectations without good cause and which no-one will pay for in the long term.

The last two of these are of key importance to NHS providers and their purchasers. If we do not have a system to give these assurances, we risk having some Trusts regard R&D as a parasitic activity which puts burdens on them without producing benefits which they understand and support.

That is why the Culyer Report proposes making the researcher and the NHS host *joint sponsors* of a research proposal which has service implications. If the NHS provider has to sign up to a research proposal, it can be sure of the extent of the commitment the NHS is making and meet its obligations.

Question 15:

Professor Martin Harris, Vice Chancellor of Manchester University, has told us (Q173): "What is absolutely clear is that the capital costs of hospital rationalisation, in so far as they affect university-embedded medical accommodation, do need to fall to the Department of Health. That I think is now accepted . . .". Is he right? In what cases has the Department of Health met such costs?

Written reply:

Many major capital schemes involving university facilities have been planned and built over the years. Apportionment of costs has usually been settled amicably at local level and I am not aware of particular cases where capital costs of university accommodation have been specifically identified for funding by the Department of Health. Most of these schemes are planned over many years and universities quite reasonably do not expect the NHS to pay for new or improved facilities for their own purposes.

More recently there have been suggestions that capital schemes aimed at improving NHS facilities or the effectiveness with which NHS services are provided may require perfectly adequate university accommodation to be reprovided or relocated. NHS Executive guidance, "Capital Investment Manual, Business Case Guide", already issued to the NHS, made it clear that such costs would need to be taken into account in decisions about the cost benefit balance of such schemes.

*14 March 1995]**[Continued]*

In particular three fundamental principles are agreed:

- early information must be provided where NHS developments are likely to have implications for University facilities;
- the costs and benefits for education and research should be taken into account and, where possible, separately identified within the investment appraisal for any NHS capital scheme;
- any costs falling upon the university should ordinarily be proportionate to the education and research benefits which will accrue.

The Department is confident that where planning is carried forward on the basis of these principles, there will be few if any problems.

However, as a recognition of the continued anxiety from the university sector, the Department is working with the Department for Education, the Higher Education Funding Council for England and the Committee of Vice-Chancellors and Principals to clarify the position and draw up explicit guidance. This work is progressing and further guidance will be issued in due course.

Question 16:

We gather that when a new treatment is offered alongside familiar treatments for purposes of evaluation, there is doubt where the excess service costs of treatment being evaluated should fall. Is this a real question? What is the official answer?

Written reply:

In his evidence to the Committee on 1 November, Professor Peckham explained that in such cases, the Department would expect those responsible for purchasing care to be responsible for purchasing the patient costs of that new form of treatment. This may sometimes need to be through purchasing consortia. An early dialogue with purchasing managers is therefore necessary from the outset of the evaluation. This is already beginning to happen.

Question 17:

It has been suggested that, as a means of bringing together the health departments and DfE, SGUMDER is not as effective as it used to be, and that the Ten Key Principles are not being adhered to. Is this fair comment? If the Ten Key Principles can no longer be applied, is it proposed to produce a new basis for joint planning between the departments for health and education?

Written reply:

The Department has no evidence of any specific or generalised failure to take proper account of the Ten Key Principles. However, the Joint Medical Advisory Committee of the Higher Education Funding Council is currently carrying out its third monitoring exercise. Part of its remit, taken on at the express request of the Steering Group on Undergraduate Medical and Dental Education and Research (SGUMDER), is to assess the extent to which the Ten Key Principles are being adhered to and are still relevant to the changing pattern of University/NHS interactions.

It would not be appropriate to anticipate in detail the outcome of that exercise. If this exercise reveals any need to update or amend the guidance to the NHS or indeed to revise the Principles themselves, this will obviously be taken into account.

The Department was surprised that doubt is being cast on the effectiveness of SGUMDER as a consultative forum between the Health Departments and the Department for Education. SGUMDER is not only a means of bringing together the Health Departments and the Department for Education; it brings together a wide range of interests including the NHS, the Committee of Vice-Chancellors and Principals, the Medical Research Council, the Association of Medical Research Charities, etc. The Department believes SGUMDER continues to be the effective means of keeping under review matters of joint interest relating to undergraduate medical education and research.

SGUMDER is not there to solve all the problems but it does keep the position under review and ensure these problems are addressed. The Department believes it carries out that task effectively.

14 March 1995]

[Continued

Further memorandum by the Department of Health

QUESTIONS FOR WRITTEN ANSWER, 7 MARCH 1995

Question 1 *Please explain the intended functions and powers of the new post of NHS Director of Trials*

1. The NHS is a test bed for trials funded by industry, charities, universities, research councils and the NHS itself. This work plays a vital role in improving patient care, scientific understanding and the wealth of the nation. This country has an excellent record in trials, but there is a need for improved co-ordination and for faster and more efficient development and completion of trials in areas of major clinical uncertainty, and for involving a larger proportion of patients in such trials.

2. The Director of R&D, Professor Peckham, has asked the newly appointed Director of Trials to draw up proposals for an NHS Strategy for Trials in consultation with all interested parties. It is envisaged that within this strategy the Director will promote more effective joint working between the NHS, other research funders and specialist associations to facilitate the development, co-ordination and support of trials of national importance.

Question 2 *When the NHS commissions research (in accordance with CRDC priorities), is there a bar on placing the work overseas? Similarly, is RHA-funded research restricted to researchers within the Region?*

3. There is no bar on placing NHS R&D work overseas.

4. RHA-funded research is not restricted to researchers within the region.

Question 3 *According to the Culyer report (paragraphs 3.36-3.40), some research now taking place in the NHS is "not worth supporting" and should be stopped. How is it proposed to identify such research?*

5. The Secretary of State announced the Government's response to the Culyer report on 15 December 1994. The press release which accompanied the announcement made it clear that:

"It is important that all R&D in the NHS should be subject to appropriate scientific quality control. However, this should not involve setting up systems of research assessment which duplicate those already in existence."

6. The press statement went on to say that the NHS will move towards supporting only that work which is adequately peer reviewed. The process of assessing NHS R&D will be considered further as part of the work which has now started to implement this policy in the context of the NHS R&D Task Force (Culyer) recommendations.

7. A copy of the press statement (Number 94/589, 15 December 1994) has already been forwarded to the Committee.

Question 4 *The Culyer report recommended (paragraph 4.2) that a "small interim group should be established immediately to identify clinical trials of national importance which are at risk . . . the NHS Executive should then ensure that adequate funding is made available". Has this been done?*

8. Discussions have been held on interim arrangements for the funding of clinical trials prior to the implementation of the main recommendations in the Culyer report. Agreement has been reached with the Medical Research Council (MRC) on these arrangements which are the subject of an Executive Letter (EL) from the Department. A copy of EL(95)33, which sets out the interim NHS support for MRC-funded clinical research is attached.

9. Departmental and MRC officials are meeting regularly to oversee the operation of these principles and to seek solutions to any unresolved problems.

Question 5 *Professor Culyer has told us, "Possibly the single most simple and effective action that could be taken to promote the adoption of effective (and cost effective) knowledge-based medical and other health care practice in the UK would be for effective commissioning and use of the results of R&D to be made an explicit target for chairs of Regions and Authorities". Is this a practical proposal?*

10. Action to promote the dissemination of knowledge-based medical and other health care practice has taken place through the Planning and Priorities Guidance (PPG) for the NHS: 1995-96 (EL(94)55). This guidance identified the 10 national priorities for the NHS in 1995-96 and the year ahead. Objective G from the PPG is as follows:

"Invest an increasing proportion of resources in interventions which are known to be effective and where outcomes can be systematically monitored, and reduce investment in interventions shown to be less effective."

Success criteria for 1995-96

G1 Programmes of action are agreed between regional offices and purchasers, and between purchasers and providers to build on progress made locally to date to achieve substantial improvement in clinical effectiveness including, as a minimum

— An increase in the use of clinical outcome specifications and audit criteria in contracts;

14 March 1995]

[Continued]

- An increase in the value of services provided which are informed by high-quality evidence of clinical effectiveness (using EL(993)115 and a complementary EL to be published in August 1994) with at least two made the subject of clinical audit;
- Increased investment in 1995–96 in at least two interventions known to be effective;
- Reduced investment in 1995–96 in at least two interventions which have been identified as less effective.

G2 Health professionals are actively involved in the contract process and feel able to own activity and quality standards.

G3 Managers and health professionals are actively involved in setting research and development agenda, defining issues for research of value to the NHS and supporting such research”

11. Corporate contracts between the NHS Executive and local purchasers provide the agreements through which the national agenda including that on promoting and adoption of cost-effective practices is taken forward.

12. The PPG is sent to General Managers (Trusts, Health Authorities and Family Health Authorities) for action and is copied to the Chairs of RHAs, DHAs, Trusts and FHSAs.

Question 6 *When we met Professor Packham in November, he indicated that various options were under consideration for the support of curiosity-driven research, including “provision for it as part of the research facilities contract” or “a specific reserve” (Q14). Has thinking advanced since then?*

13. This will be progressed as part of the work which has now started to implement the policy set out in the 15 December statement about the NHS R&D Task Force (Culyer) recommendations.

Question 7 *How will the size of the research levy for 1996–97 be determined and when?*

14. An announcement will be made in the near future.

Question 8 *What is the current date of planning for support of NHS-funded clinical academic posts following the abolition of the RHAs?*

15. Currently RHAs devote specific funds, through Regional top-slicing, for academic posts. Following the abolition of RHAs, it will be necessary to have in place mechanisms which will adequately deal with this particular funding stream if existing and unavoidable commitments are to be honoured and if relationships with the universities are to be maintained and strengthened.

16. A questionnaire was sent to Regions in August 1994 to obtain specific information about funding arrangements and, broadly, the nature of activities it supported.

17. Responses showed that some 577 WTE posts valued at £21 million were being supported by Regions.

18. The NHS Executive Board has agreed that financial provision from 1996–97 for these posts will be met by local purchasers or from one of the proposed national levies, as determined by Regions. It is expected that guidance on this matter will be issued to the NHS shortly.

Question 9 *Professor Peckham assured us in November that the problem of the career path for clinical academics was “something which we are giving a lot of attention to” and a “high priority area” for RDRDs (Qu. 38). What is being done? He mentioned 123 fellowships and 36 studentships supported by RDRDs: is this funding secure?*

19. Since November, a series of advisory studies have been completed, and a research capacity strategy is now in preparation. The Central Research and Development Committee (CRDC) will advise on the apportionment of the R&D budget to the research capacity sub-stream of the NHS R&D single funding stream.

Question 10 *The CDMS tell us that, in London, “For several sites the next few years may prove rather difficult while extensive building programmes are brought to fruition. The worst outcome would be that the present Government did not release sufficient capital to implement the changes speedily or a successor government halted them in mid-stream. The NHS must recognise the fundamental importance of the clinical academic base to its present quality and its future strength. There are welcome signs that this point is beginning to be understood. Provided that the different schemes can be completed by the turn of the century, London should emerge with five of the largest and strongest medical schools in the country . . . An enlightened government might wish to protect London academic medicine through this phase of transition so that it can remain a world class medical centre into the next century” (p. 76). Can adequate capital provision be expected?*

20. The Government is committed to making resources available to fund projects arising from “Making London Better” to provide a better balanced hospital service on fewer sites. Each project is, of course, subject to the normal process of business plan development and approval, including consideration of the Private Finance Initiative. It is not possible to give an undertaking to underwrite all future costs regardless of the circumstances prevailing at the time.

Question 11 *What action has been taken in light of the Williams review of DH-funded research units?*

14 March 1995]

[Continued

21. The Review of the Role of DH-funded Research Units: strategies for long-term funding of Research and Development (the Williams Review) was published in March 1992. The review recommended a strengthening of the long-term research infrastructure by the creation of a small number of larger centres on 10-year contracts. The first steps in the implementation of these recommendations have now been completed. A National Centre for Research and Development in Primary Health Care has been set up at Manchester University and peer review site visits to all research units have been completed as part of a policy of regular review. Confirmation of continuing financial support for all research units for a further five years has also been given.

22. The establishment of the larger research centre and confirmation of continued support for the units means a framework for a more satisfactory career in health and social services research is put in place by providing:

a cadre of experienced health services research staff with more satisfactory funding arrangements and career structure, in an inter-disciplinary environment; and an appropriate career structure within reasonable security of tenure to attract good entrants and so maintain the cadre.

23. To support career development, Departmental funding includes provision for studentship and research fellowships, higher degree registration, participation in taught courses for higher degrees and attendance at conferences.

Question 12 On 22 February, "The Times" reported plans for a new system to regulate and register new medical and surgical interventions. Please tell us about this.

24. Discussions have been taking place with the Conference of Colleges about the development of a system for identifying major new technologies in the NHS and for ensuring that appropriate decisions are made about the sort of evaluations required before a procedure comes into wider use. This resulted from discussions between the DH and the profession on the ACOST recommendation:

that the health departments establish a committee on safety and efficacy of procedures to review and register novel surgical procedures.

25. A paper was sent to the December 1994 meeting of the Conference of Colleges and agreed in principle. We are encouraged by the progress made so far, but the details of the scheme still need to be worked out.

Question 13 The ACOST report on "Medical Research and Health" recommended that clinicians involved in clinical trials should be trained in "Good Clinical Practice", and that the Government response accepted this recommendation. What is "Good Clinical Practice" and what is being done about it?

26. This will be addressed by the research capacity strategy which is being prepared.

Further Memorandum by the Department of Health Advisory Group on future arrangements for allocating funds and contracting for NHS Service Support for teaching medical undergraduates

Gerald Malone, the Minister for Health, has asked Graham Winyard, the Department of Health's Director of Health Care, to chair an Advisory Group on future arrangements for allocating funds and contracting for NHS service support for teaching medical undergraduates, ie the "T" of SIFTR¹.

The establishment of the Advisory Group follows from the proposed abolition of regional health authorities and the recommendation in Professor Culyer's report for a single funding stream for research which would include the "R" element of SIFTR. Copies of the Advisory Group's terms of reference and membership are attached.

TERMS OF REFERENCE

To recommend future arrangements for allocating funds and contracting for NHS service support and facilities for teaching undergraduate medical students.

The review will take into account:

- the proposed abolition of Regional Health Authorities (subject to Parliamentary agreement);
- developing financial policies for NHS allocations to purchasers, for levies to support common services, and for NHS standards of costing and accounting;
- the disaggregation of SIFTR into separate funding streams for undergraduate teaching and research as from 1 April 1995;
- developments in undergraduate medical education, including increased time in community and primary care;
- the need for transitional arrangements to avoid unplanned, significant changes in funding for individual providers or purchasers.

¹ Service Increment for Teaching and Research.

*14 March 1995]**[Continued***Future arrangements should:**

support the Secretary of State in discharging her statutory duty with regard to facilities for teaching clinical undergraduate medical students;

provide for effective consultation between NHS providers, purchasers and those responsible for medical education;

take account of both marginal NHS costs of each student and overall NHS costs of providing facilities for undergraduate medical education;

provide incentives to maintain and enhance the quality of medical undergraduate teaching and to improve value for money;

be demonstrably equitable for NHS providers and purchasers in different parts of the country;

keep management costs for NHS bodies, universities and the NHS Executive to the minimum necessary to ensure proper accountability for public money.

The review will offer recommendations to Secretary of State by March 1995, with a view to their taking effect, after appropriate consultation, in April 1996.

MEMBERSHIP*Chairman*

Dr Graham Winyard, Health Care Director, NHS Executive

Members

Professor Michael Bond, Vice-Chancellor, Glasgow University Medical School, and Chairman of the Joint Medical Advisory Committee of the Higher Education Funding Councils

Barry Dowdeswell, Chief Executive, the Royal Victoria Infirmary, Newcastle

Cathy Hamlyn, Chief Executive, Sheffield DHA

Dr Robert Hangartner, Senior Principal Medical Officer, Health Care Directorate, NHS Executive

Vicky Hardman, Chief Executive, Camden and Islington DHA

Professor Frank Harris, Dean, Leicester Medical School

Professor Martin Harris, Vice-Chancellor, Manchester University

Professor Richard Hobbs, General Practice Teaching & Research Unit, Birmingham University

David Pace, Finance Director, Thames South

Aileen Simkins, Assistant Secretary, Health Care Directorate, NHS Executive

Professor Gilbert Smith, Deputy Director of Research & Development, NHS Executive

Dick Stockford, Assistant Secretary, Purchasing Unit, NHS Executive

Robert Tinston, Regional Director, North West

Dr Pat Troop, Director of Public Health, Anglia & Oxford

Membership of the Advisory Group will also include a Medical Director from a university hospital trust and a GP fund holder.

Secretariat

Mark Fuller, Principal, Health Care Directorate, NHS Executive

Jane Adaoui, Higher Executive Officer, Health Care Directorate, NHS Executive

Peter Cockett, Executive Officer, Health Care Directorate, NHS Executive

14 March 1995]

[Continued]

Further Memorandum by the Department of Health. Future arrangements for NHS support of medical undergraduate teaching: The Advisory Group on SIFT

INTRODUCTION

1. The Select Committee asked Dr Winyard, when he gave evidence on 7 February, about progress in the Advisory Group which he is chairing, at the request of the Minister of Health, to

make recommendations on the future arrangements for allocating funds and contracting for NHS service support and facilities for teaching undergraduate medical students.

2. After a brief discussion (583-584), the Chairman suggested that Dr Winyard should let the Committee have a memorandum on the principles underlying the Advisory Group's work.

KEY ISSUES FOR THE ADVISORY GROUP

3. The terms of reference for the Advisory Group set out clearly the main areas for consideration.

4. The Advisory Group will seek in their recommendations to:

support continued partnership between the NHS and universities, developing within the Ten Key Principles in the Second Report of the Steering Group on Undergraduate Medical and Dental Education and Research;

support educational innovation in implementing the new General Medical Council curriculum in "Tomorrow's Doctors", particularly in providing fair funding for clinical placements outside main teaching hospitals, including general practice;

ensure SIFT payments to major teaching hospitals are based on understanding of their costs and on strategies for teaching and for health care, agreed with the university and with NHS purchasers, and avoid financial instability;

support the creation of separate funding streams for NHS support to teaching and for research, but seeking complementary processes where possible, such as funding for facilities in teaching hospitals which support both teaching and research;

move progressively towards using information on identified NHS costs of support to teaching to ensure money is well spent and to improve accountability, within a national framework for SIFT.

5. The Advisory Group has discussed ways of achieving these aims, including the basis for payments to each hospital (or other teaching environment) and the roles and responsibilities of the main parties (universities, headquarters and regional offices of the NHS Executive, district health authorities, NHS Trusts and GPs).

6. The Advisory Group is likely to recommend some clear minimum responsibilities for regional offices, university medical schools and for DHAs who are major purchasers from teaching hospitals, including the need for agreement on local strategy for NHS support to teaching and on the deployment of SIFT funds.

7. The Advisory Group is considering whether there is benefit in a division of SIFT into clinical placement payments, paid to the Trusts or GPs where students spend time during their clinical training, and facilities payments to cover additional costs of providing a teaching environment. The responsibilities for planning and negotiating payments might be different for the two funding streams, with medical schools having a particularly strong role in relation to clinical placements.

8. The Group is likely to recommend a framework for accountability for SIFT expenditure, at national and local level. Outputs—the extent to which intended educational aims are achieved—are important as well as input costs.

TIMESCALE

9. The Advisory Group will submit a report to the Secretary of State for Health by the end of March. Subject to Ministers' views on the report, there is likely to be a period for wider consultation on the way forward. Decisions on significant changes to take effect in 1996-97 would need to be known by summer 1995, because of the potential implications for NHS planning and contracting.

10. Ministers would value any comment the Select Committee wish to make on this memorandum, or at a later stage.

14 March 1995]

[Continued

TERMS OF REFERENCE

To recommend future arrangements for allocating funds and contracting for NHS service support and facilities for teaching undergraduate medical students:

The review will take into account:

- the proposed abolition of Regional Health Authorities (subject to Parliamentary agreement);
- developing financial policies for NHS allocations to purchasers, for levies to support common services, and for NHS standards of costing and accounting;
- the disaggregation of SIFTR into separate funding streams for undergraduate teaching and research as from 1 April 1995;
- developments in undergraduate medical education, including increased time in community and primary care;
- the need for transitional arrangements to avoid unplanned, significant changes in funding for individual providers or purchasers.

Future arrangements should:

- support the Secretary of State in discharging her statutory duty with regard to facilities for teaching clinical undergraduate medical students;
- provide for effective consultation between NHS providers, purchasers and those responsible for medical education;
- take account of both marginal NHS costs of each student and overall NHS costs of providing facilities for undergraduate medical education;
- provide incentives to maintain and enhance the quality of medical undergraduate teaching and to improve value for money;
- be demonstrably equitable for NHS providers and purchasers in different parts of the country;
- keep management costs for NHS bodies, universities and the NHS Executive to the minimum necessary to ensure proper accountability for public money.

The review will offer recommendations to the Secretary of State by March 1995, with a view to their taking effect, after appropriate consultation, in April 1996.

27 February 1995

Examination of witnesses

PROFESSOR MICHAEL PECKHAM, Director of R&D, Department of Health, was called in and further examined; PROFESSOR SIR MILES IRVING, Professor of Surgery, Hope Hospital, Salford, Chairman, CRDC Standing Group on Health Technology, PROFESSOR STEPHEN HOLGATE, Southampton General Hospital, Associate RDRD, South and West RHA, NHS Director of Trials, PROFESSOR GEORGE ALBERTI, Director of R&D, Northern and Yorkshire RHA, and PROFESSOR ANDREW HAINES, Director of R&D, North Thames RHA, were called in and examined.

Chairman

1266. Thank you very much, gentlemen, for coming to see us and for being willing to discuss with us a number of the crucial issues relating to the future of R&D in the NHS.

(*Professor Peckham*) Thank you very much. We are delighted to be here and I am pleased to return for a second time before the Committee. What I would like to do, with your permission, is to ask my colleagues to each say a word about their role in the R&D programme, following which I might perhaps make a brief statement about the implementation of the Culyer report and the development of a single plan for the regional and central R&D staff. If that is acceptable, perhaps I could ask Miles Irving to start?

1267. Yes.

(*Professor Sir Miles Irving*) Thank you very much. I started off in the R&D exercise as a Regional Director for the North West. That was a challenging time, because we had to convince those in the Health

Service community of the relevance of Health Service research and also to show the relevance, particularly to the academic community, of the change in direction which we were making. It was a very stimulating time because it was a question of changing hearts and minds, but it was one that in the end was I think very successful. I had a lot of support particularly from my academic colleagues, but, also, of course, from the other universities in the region who really had a great deal to offer and who had not been primarily involved in health services research in the past but who were being brought into the framework. During this time I think the role of the Regional Director was crucial because in my view the messenger was as important as the message. It became quite clear that to have somebody who was actually a practising clinician and who had some credibility in the field of biomedical research taking forward a message about the importance of Health Service research was a major factor in the success that we achieved. As you know, the regions were

14 March 1995]

PROFESSOR MICHAEL PECKHAM, SIR MILES IRVING,
 PROFESSOR STEPHEN HOLGATE, PROFESSOR GEORGE ALBERTI
 AND PROFESSOR ANDREW HAINES

[Continued]

[Chairman *contd.*]

fused and in April 1994 I moved over to the Health Technology Programme and became Director of Health Technologies. I again found this a challenging and interesting exercise. I have found it particularly rewarding because I think it is the most easily understood and readily accepted part of the R&D initiative by the Health Service community. We approached the Health Service community to ask them about areas of uncertainty in the practices that they were carrying out using their existing technologies. Needless to say, as you know from the report that we published, we got an enormous response and in the first consultation exercise right across the Health Service community we had 1,400 submissions from people saying "These are areas of uncertainty in our practice". The extent of this response was very rewarding. This led on to two other aspects: first of all, with such a large number of submissions we had to look at how to prioritise these submissions. As you know from our report, we set about a prioritisation exercise which was really a very interesting and valuable exercise was primarily devoted to existing technologies. It is important to realise that people also recognised the challenge posed by developing technologies. I think with the increase in technology that is coming from advances in science and pharmaceuticals the professions themselves have valued the opportunity to take part in an appraisal of the evidence relating to the technologies which they use and to which they are being exposed. Our prioritisation exercise was carried out by multi-disciplinary panels who were supported by a scientific secretariat. The secretariat was very important in presenting the panels with what we called vignettes of the scientific evidence on the existing situation. They could then make a judgment of how much was known and the priority for assessment. One of the things we found was that the methodology for undertaking this new type of research was not widely available and, as you will recall from our report, one of the major panels we have set up is the methodology panel to develop methodologies for assessing health services research. Research, by and large, within health technology assessment is by the use of systematic reviews and also by primary research. The systematic review is very important because it looks at the existing evidence and you are well aware of the work of Iain Chalmers and the York centre in undertaking these reviews which are very different from the reviews that are currently used. I think one of the interesting effects of what we are doing is on the whole question of the control of new technologies whilst they are being investigated. I think it is very rewarding that the Department of Health have supported our activities so that when we make a judgment that a technology needs assessment, then through the medium of an Executive letter, that technology's use is controlled until the results become available. I think this is a very major step forward but one which has been accepted particularly by the professions. I can quote, for example, within my own field of surgery the use of laparoscopic resection of colon cancer. As you know, this is an unproven technology. Already there are some concerns that it may be associated with a high local recurrence rate at the site of the insertion of cannulas. It is rewarding that the

Royal College of Surgeons, the Association of Coloproctology and the American Society of Colorectal Surgeons have all agreed that this technique should only be used within the context of trials until the results become available. I think this is a most welcome change in attitude on behalf of the medical professions to new technologies. I would conclude with two major issues: the first relates to the problem of how we use the results of these studies when we get them. In my written submission to you I pointed out that one of the major problems is that when we have results from research is actually putting that research into practice for example through our so-called GRIP exercise. The major challenge to us as to how we are going to disseminate the information and have it used. I think there are many ways and, as you know, as part of the R&D exercise this is being addressed. When we have that information one of the most exciting ways to disseminate it will be to put that information into the hands of the public. This is a challenge that I look forward to because I think it is likely to be an extremely effective one. Finally, I conclude by saying that another exciting aspect of our work is the Foresight exercise. We are looking at new technologies coming over the horizon, trying to identify those of significance so that we know about them before they really hit us. Laparoscopic surgical technology really landed on us before we could assess it in a controlled way and I think we want to avoid that as far as possible. We are certainly going to be able to do that in the future through the establishment of the foresight initiative within the Health Technology Programme for identifying new technologies so that we can be forewarned about them, and arrange the setting up of assessment mechanisms. Chairman, I would like to pause there.

1268. Thank you, Sir Miles.

(*Professor Peckham*) Could I ask George Alberti perhaps to say a few words on both his role as a Regional Director of Research and Development and also his national function in cardiovascular disease, stroke, mental health and nutrition.

(*Professor Alberti*) Thank you very much. I reiterate what Miles started off with about the excitement of the early years, especially when at that stage it was just the Northern region with which I was dealing - a nice small provincial area, as you know, that was not difficult to deal with. There was a mind-set problem and the initial response of my colleagues in the teaching hospitals, of course, was that this was a lot of extra money for them and the initial response of everyone else was that all the money would go to Newcastle. I think we have dealt with both these problems. A lot of what we do is consultation with the purchasers/providers all round the region; one of the most important things about the R&D directors are the networks you establish, so that you find out quickly what is going on and what people want to go on. I think that has been very important, as has a role that I have adopted which is facilitating the getting together of multi-disciplinary groups. As the region has enlarged I think this has been particularly important in bringing people together from places like Huddersfield and Berwick-Upon-Tweed and Carlisle, i.e. wherever there is someone with an

14 March 1995]

PROFESSOR MICHAEL PECKHAM, SIR MILES IRVING,
PROFESSOR STEPHEN HOLGATE, PROFESSOR GEORGE ALBERTI
AND PROFESSOR ANDREW HAINES

[Continued]

[Chairman contd.]

interest in a particular area, and I think it is starting to generate much better research ideas, and much better research. Another major resource are the universities and again we have regular meetings now with universities of the northern half of the region and the southern half, and occasional meetings of all 12 universities. There is of course health research going on in all 12 and it is again bringing out what is good there and using that I think is very important. One of the other local things we do is identifying local needs; and one of the strengths in the north has been looking at socio-economic deprivation and ill health and again we are working on that and building on that. There are other local problems that we can deal with which would be much more difficult at a national level. I think another important role is in training at all levels. We fund studentships in health services research and we fund training fellowships across the board so we are not restricted to health services research there. We want good research workers to develop; so there are one-year training fellowships to get people on the way, all of which have an obligatory connection to a taught component. The new region provides some particular problems. Geographically it is enormous. You can have a full-time director who spends all his time travelling around but I do not think that helps particularly. What we have done is appoint associate directors who will look after parts of the region and I work closely with them. We are also addressing specific problems: for example the teaching hospitals are particularly concerned at the moment (and I meet with the Chief Executives of the four teaching hospitals in the region, or what they call university hospitals now, to look and hear what they have to say), so we are trying to help with problems of clinical research, and on clinical research beds (which is something near and dear to my heart). Finally, the sort of emphasis locally again is more and more now on taking known research, and on dissemination and implementation of the findings, and you will hear more about that from others. That is fairly challenging. On the national front we manage two main programmes, cardiovascular disease and stroke and mental health and they run pretty smoothly. We have taken the best from organisations like the MRC in setting up the way we do it and we have, I hope, eliminated quite a lot of the worst as well and I think it is working quite well. We work closely with people like the MRC on those programmes and it is quite a big budget and we are also now setting up diabetes and nutrition programmes. We have just finished an exercise to look at priorities from a Health Service point of view which complements what the charities and the MRC are doing. I think that gives a fairly snappy picture of what I see as our activities.

1269. Thank you. Do you think it likely that your role and responsibilities will change significantly with the new Health Authorities Bill and the abolition of regions in their present form or do you feel that the new situation will enable you to continue with this work based upon the regional office of the NHS management executive?

(Professor Alberti) I think it will strengthen our role actually in a funny sort of way. We will have a major role in the regional office and that has already

emerged in Northern and Yorkshire and we are given a free hand to get on with putting R&D on the map in the region.

1270. Do you believe it is likely that something comparable to the present locally operated clinical research schemes will continue and is it also likely that the regions will be in a position to fund, as they have done in the past, clinical academic posts in the hospitals through the region?

(Professor Alberti) The first of those two questions is much easier to answer and the answer is yes. We have 25 per cent of our budget—and it varies from region to region—set aside for pilot schemes, curiosity-driven research, and small grants very much across the board to encourage the whole research community and we have put a lot of emphasis on maintaining that. The second is a trickier question in terms of who is going to fund academic posts, although what we have found in the north is that the trusts over the past two years have funded a very large number of new academic posts.

Lord Perry of Walton

1271. Do you think that the directors of research in the new situation will continue to be part time?

(Professor Alberti) I think it is possible. I like the model because I think that one of the things we have done successfully is we have credibility as, at least, only “gently downhill-moving” academics. I think with the full time ones you could get someone seconded and I think that is a model. I prefer the part-time model with the associate directors if possible.

(Professor Peckham) There is no doubt that there is a full-time job to be done. The challenge is to reconcile the need to undertake this very full task with the need to recruit academics who are credible, who have strong research track records. We envisage that these might be full-time appointments on secondment or they might be part-time appointments with a job share with one person designated regional director of R&D and supported appropriately. Can I just comment on the future of academic posts. I do not think there is any intention to stop such appointments which can continue to be made in appropriate circumstances. The funding arrangements for research and, indeed, for education will permit the support of clinical academic posts when the case can be made. I have asked Stephen Holgate, who was the Regional Director for Research and Development in Wessex, to prepare a strategic plan for clinical trials in the Health Service. He is in the process of doing this and perhaps he could say a word or two about that.

(Professor Holgate) By way of introduction, I am an MRC Clinical Research Professor in Southampton and still have a very firm foot in the bio-molecular camp in my special area of interest which is asthma and air pollution. I feel strongly that the credibility of the R&D exercise does have to have a strong investment in the bio-molecular and clinical basis of medicine. Turning to clinical trials, I think it is becoming increasingly apparent that the United Kingdom with its National Health Service provides a unique national test bed, which has never been fully

14 March 1995]

PROFESSOR MICHAEL PECKHAM, SIR MILES IRVING,
 PROFESSOR STEPHEN HOLGATE, PROFESSOR GEORGE ALBERTI
 AND PROFESSOR ANDREW HAINES

[Continued]

[Lord Perry of Walton *contd.*]

utilised to implement clinical trials. It has the potential to organise, in a far more constructive manner, the conduct of clinical trials within the provision of health which would embrace trials not only from the pharmaceutical industry (a revenue earning aspect of the Health Service which I think could be very advantageous), but also clinical trials that are post-registration. In other words trying to help us position drugs within the Health Service so that they may be targeted to those patients who may best benefit from them, a task that the MRC and other sponsors of research, including the research charities as well as the private sector, are very much interested in. I see it as a unique opportunity for bringing together key organisations, such as the Association of the British Pharmaceutical Industry (ABPI), the MRC, the Association of Medical Research Charities and NAHAT, into a single forum to discuss how best we can put together a strategy for clinical trials in the United Kingdom. This might include the provision of a register of those who are interested in participating as a specialist centre for a particular specific field of interest. A second area relates to the provision of training and education in clinical trials of which there is very little at the moment in the United Kingdom. The third and fourth relate to ethics and the indemnity aspect of clinical trials where at the moment there is considerable confusion. Bringing the various parties together to discuss these issues and to facilitate the development of a National Strategy for Clinical Trials should open up a unique opportunity for us in the next few years. I would like to suggest to your Lordships that we think about one (or more) centres for clinical trials in the United Kingdom a little bit like the Cochrane collaboration in Oxford where there can be a focus of expertise, where people can consult industry, the Health Service and those wishing to train in clinical trials so that a much more effective system can be produced for conducting clinical trials in the United Kingdom can be developed than has been hitherto the case.

Chairman

1272. One problem that has been brought to our attention has been that certain of the purchasers appear to be reluctant to pay for the extra-contractual and tertiary referrals upon which certain clinical trials in rare diseases may depend. How would you see this matter being handled?

(*Professor Holgate*) This is a very important matter. What is needed is concrete evidence and specific examples to gain evidence of this. I think what we need to find is clear evidence of where there are difficulties and obstructions relating to patient flows for R&D and then, once this is made available, to discuss possible ways of resolving the problems because the NHS R&D initiative clearly has to be engaged in opening, not closing, doors to enable patients to transfer across boundaries.

Lord Gregson

1273. It is very difficult to envisage how you will get that evidence because the only people who know are the people who are not going to refer. The patients do not know. How do you get that evidence?

(*Professor Holgate*) Already there are individuals who have identified to us specific problems with regard to cross-boundary flows of patients that are providing barriers to effective R&D.

1274. I accept that. How do you get evidence when you have got two sets of people who are not talking to each other, in effect, or do not want to talk to each other?

(*Professor Peckham*) There are two points to raise here. Professor Alberti has already referred to the networks that regional directors are developing and have developed with purchasing authorities as an important component of the R&D strategy. One of the features of the R&D programme is the multiple constituencies that are involved. Of course we relate to the academic community but we also must relate to NHS clinical staff, managers, purchasing authorities and, as Miles Irving has said, to patients and the public. In that way we will pick up information on referrals. We are also in close contact with the MRC and, indeed, the AMRC and you will remember that the point of departure for the Culyer review was the evidence submitted to us from those organisations. That will be another route. I would envisage that the new national forum will be a very useful new arena for our research funding partners to bring to us evidence of problems about referral patterns.

1275. I am not convinced. I agree with Sir Miles, of course, that once you get the patients internally educated they are the people who will say to you, "I want to go there and they are not letting me go." You have not got that, have you?

(*Professor Sir Miles Irving*) I think it is up to the research community to be innovative in its approach to this sort of research work. At the moment we have a tradition whereby patients who could take part in such research are always referred to the teaching hospitals. I have personal experience of actually taking research techniques and research methodology out into district general hospitals, where it is suitable to do so and where there is no loss to the research projects, and that has had an enormous influence in stimulating interest within those hospitals in the whole research exercise. So although I totally agree it is important that we must not inhibit the referral of relevant patients who need both clinical tertiary referral and who can be used for research, we must not forget that there are different ways of undertaking research and in the new approach that we are making it is possible to be innovative in the way we undertake that research.

Chairman

1276. Thank you.

(*Professor Peckham*) Professor Haines is the Regional Director of North Thames which is a region particularly rich in teaching hospitals.

14 March 1995]

PROFESSOR MICHAEL PECKHAM, SIR MILES IRVING,
 PROFESSOR STEPHEN HOLGATE, PROFESSOR GEORGE ALBERTI
 AND PROFESSOR ANDREW HAINES

[Continued]

Lord Gregson

1277. For the moment!

(*Professor Peckham*) He also brings the academic general practice dimension to the regional group and also to the central research and development committee and he has a number of other responsibilities and perhaps he could say a word about those.

(*Professor Haines*) In the national context I have two major responsibilities; one is for the primary secondary care interface programme. This is an innovative programme of research in an innovative area in the NHS. The advisory group generated about 20 priorities for research and this resulted in nearly 700 expressions of interest. We have now commissioned 54 research projects in this innovative area covering most of the 21 areas that were decided upon by the advisory group. It has brought together multi-disciplinary teams to attack problems in an innovative way. My other area of national responsibility is for the area of implementation. It has become very apparent in recent years that there is a big gap between what medical research shows to be an effective treatment and what is actually practised in every day clinical medicine. One of the famous examples of that is thrombolytic therapy for myocardial infarction with which many of you are familiar. The advisory group which I am chairing, advisory to the CRDC, is now looking at the spectrum of methods open to the NHS for improving the implementation of research findings. We are aware that there are a number of lessons, for instance, from industry, about ways of improving the uptake of research findings and that there are improved technological resources that we must make use of, such as computerised decision support systems which are beginning to become available but have not been widely evaluated. The group that I am chairing has come up with another 20 priorities for research in this area and we will be presenting our report to the Central Research and Development Committee in the next few weeks we hope to go ahead and commission research quite speedily on this important and growing area. With regard to the region itself, North Thames is obviously an unusual region. It has what were until recently six medical schools, gradually moving towards three large schools, most of the former SHA, and in addition to that a large number of what have traditionally been thought of as non-medical universities but many of them are now developing their own health research activities. We therefore have an important role to try to bring together specialist academics, purchasers and providers to help to foster a better understanding of each other's requirements between these very different cultures. We have a number of sub-groups within the regional R&D programme. One focuses on education and training and is funding a number of new blood lectureships and a training centre to develop the capacity to undertake systematic reviews within the region. We have found that this is an area where the region has not been strongly represented until now. We have a group on organisation and management which tries to pick up innovations within the Health Service, many of which have not been properly studied, and ensure that they are adequately evaluated. We also have a regional group which focuses on trying to get specific clinical

interventions of proven effectiveness implemented in clinical practice around the region. We also have a number of special groups which commission projects in a number of specific areas such as Health of the Nation, mental health and HIV/sexual health. Finally, of course, we have a responsive funding committee which accepts applications generated by the research community and which I can discuss further if there is time.

Chairman] Thank you very much.

Lord Gregson

1278. Perhaps I can say as an engineer that I hope you do not take too literally what industry tells you. On the whole I would think they are worse than you are at this point in time in continuing education and I recognise it is a very serious problem. Could I point out, for instance, that there were seven earthquake solutions in Japan recently demonstrated to be useless. A lot of people knew about that and that is the state of the continuing education in engineering and industry. I should look elsewhere for your inspiration if I were you.

(*Professor Haines*) We have commissioned a critical review of lessons from the industrial sector. We do not intend to take an idealised view.

Chairman

1279. Is there any danger of duplication of effort between the director of clinical trials on the one hand and the work of the Cochrane and York centres on the other?

(*Professor Peckham*) I am sure that there is not a danger of duplication. Stephen Holgate is in the process of preparing a strategy for handling clinical trials extending from phase one studies through to randomised trials. I believe that at one extreme we need to understand better how to interface the NHS with advances in science and technology, for example the rapid progress in genetics and developments in bio-engineering and materials science. Emphasis is needed on phase one studies involving the first testing of new developments in patients as well as on randomised trials. I see that as quite a distinct problem area from the systematic overviews of Cochrane and the more general research reviews of York. I wonder whether I might say a word about two of the many tasks that face us. I will identify two particular issues that pose a particular challenge over the next months and beyond. The first is that it has become clear that since the R&D programme has developed very rapidly and assumed responsibilities across a wide range of activities from science to health services research, that there is a need now to develop a single coherent plan that involves all the R&D personnel of the regions and the R&D personnel of the NHS branch in Leeds and the Department of Health in London. We are planning to develop a plan which collectively involves more than 100 R&D staff, handling a budget of more than £400 million on behalf of the NHS. There are a number of issues that flow from a unified plan. Firstly, the distinction which we drew earlier in the programme between nationally important and regionally important research will, to a large extent, disappear. There will be a single category of

14 March 1995]

PROFESSOR MICHAEL PECKHAM, SIR MILES IRVING,
 PROFESSOR STEPHEN HOLGATE, PROFESSOR GEORGE ALBERTI
 AND PROFESSOR ANDREW HAINES

[Continued]

[Chairman *contd.*]

important R&D. Secondly, each R&D director will be a part of a team and have national responsibilities because this will need to be a shared task. We expect by the early autumn to produce the first plan. The second task is to implement the new arrangements for supporting R&D in the NHS, arising from the Culyer report. Since I last appeared before the Committee the Government has responded to the recommendations of Culyer report on 15 December and we have made available to the Committee the details of that response. There were important commitments, including five new measures: a single R&D budget held centrally by the Director of Research; a levy on health authorities; an additional sum of money for R&D in the NHS; a new CRDC with a budgetary advisory role, and the creation of a national forum. The details were set out in a document "the future framework for funding and supporting R&D in the NHS" appended to the press release. There were several other important aspects. Implicit in the response is a commitment to long-term support of research which I consider to be very important. Secondly, that contracts could be with individuals, with groups or with institutions. This gives us substantial flexibility. Thirdly a commitment to extend R&D funding into primary care and community health services where it is appropriate to do so. The implementation plans for this are being driven forward as decisively and as quickly as possible. It is a complex exercise. The agenda for implementing the new arrangements will be published in the near future. I hope this will be at the end of March or in the early part of April. There are two aspects I would like to emphasise, although I cannot go into details at this stage. The first is that I recognise the need for stability. This is very important. We are introducing a new system, we want funds to support good work, but we recognise the need for stability and the need to phase the new arrangements in in a sensible way. A number of groups are already working. Stephen Holgate is chairing a group looking at service support issues and there is work on the costing methods that will be needed. The new Central Research and Development Committee has been convened and holds its first meeting on Thursday this week. It will be a briefing meeting. The Secretary of State has issued invitations to the charities and the research councils for the new National Forum which will hold its first meeting on 25 May.

1280. Thank you very much for that note on progress. I think you originally suggested a target of 1.5 per cent of the NHS budget overall to be spent on R&D and at present the figure is 1.2 per cent. How do you see the prospect of moving towards that enhancement of funding for R&D?

(*Professor Peckham*) In a sense this takes us to the first of your questions in paragraph one about the adequacy of money to maintain R&D infrastructure. I believe the conclusion that is reached or implied in the statement is somewhat problematical because the purpose of implementing the new arrangements is to move away from beliefs or assertions that there is or is not enough money and to demonstrate what the need is for service support, what the need is for facilities, and to match resources with those

requirements. This is the approach being adopted in implementing the Culyer recommendations. In terms of the budget increasing from 1.2 to 1.5 per cent, there are two points to be made there. One is that we do need to develop the mechanisms for identifying implicit research funding, in hospitals, and that will be put into operation as soon as possible. On the other hand, we have a continuous build-up of budget. The Secretary of State announced an additional £8 million for research funding and there was an additional sum of money to supplement SIFTR last year with the indication that if the case was made it would be looked on favourably in order to build up the research budget to 1.5 per cent.

1281. Do you envisage any problems in relation to the levy on purchasers, including fundholding general practitioners?

(*Professor Peckham*) No, I believe that we have moved very substantially from a position in which at the beginning of the Culyer discussions some purchasers felt that research might be commissioned by them at a local level, to a recognition that you cannot fragment research and ensure quality and that we need to raise a common levy on all health authorities. This is accepted.

Lord Perry of Walton

1282. I very much commend what has been happening especially since I was a member of this Committee when we suggested that this should start in the way of health services research. What I am bothered about is the fact that up until now the whole of SIFTR goes to the medical schools. Under the new situation 25 per cent of it will be up for grabs and the only thing that the medical schools can count on continuing getting is the 75 per cent. Do you think the medical schools are currently over-funded because what they will get from their bidding against all health services research is totally unknown? Almost certainly it is bound to be less than the current total that they are getting.

(*Professor Peckham*) These are precisely the issues that we are working on in the detailed implementation plan of the Culyer recommendations and I would not want to preempt those decisions. However I would return to the point I made earlier which is that the intention is to calculate how much is needed to support research facilities, to support the service costs of research in teaching hospitals. I do not believe that teaching hospitals carrying out good research and where there is a case for long-term support as well as service support have anything to fear from these recommendations.

1283. You said specifically those teaching hospitals that are doing good research. I wonder whether there are many teaching hospitals that are doing bad research. It could be said that the R budget that is available to you for health services research should be a budget that is made up from a total that excludes the whole of SIFTR as it currently stands. You said you were sympathetic to the idea of increasing the SIFTR budget. If it was increased to a point where the medical schools continued to get a sum approximately equal to what they are getting

14 March 1995]

PROFESSOR MICHAEL PECKHAM, SIR MILES IRVING,
PROFESSOR STEPHEN HOLGATE, PROFESSOR GEORGE ALBERTI
AND PROFESSOR ANDREW HAINES

[Continued]

[Lord Perry of Walton *contd.*]

now then nobody would have any objections at all. Is this likely?

(*Professor Peckham*) As I have said before, I do not think that medical schools that are carrying out good research will be disadvantaged but we do need a clear basis for establishing how much funding is needed to support individual medical schools. To return to the point about good and poor research; I suspect that all of us have had experience of poor research being carried out in institutions where good research is being conducted and this is something that we have every intention of correcting because the funds that are associated with poor research must now be used in a much better way as part of the new arrangements. Perhaps my colleagues would wish to comment.

(*Professor Holgate*) One of the responses to the Culyer Report is that many teaching hospital institutions have established, or are in the process of establishing their own R&D directorates with an identified R&D director, often a part-time but very high calibre person, whose charge is to capture what R&D activity is being undertaken in that particular institution. This incorporates the easily identified explicit research which is grant funded but also the large amount of intrinsic (pre-protocol) research which is not accounted for at the present time and for which there is very little information about. As these institutions start to capture what is happening in their own locality there is bound to be some strategic re-orientation as to how funds within a trust is going to be used to meet particular areas of interest, taking advantage of specific expertise.

Lord Perry of Walton

1284. Most of the biomedical research that is going on is going on through the university departments in the teaching hospitals. The additional research would tend to be more directed towards health services research?

(*Professor Peckham*) Of course the research of the Medical Research Council and of the charities involves the use of NHS resources, their clinical research will be a call on the NHS R&D budget. What we are in effect putting in place is a second dual support system. HEFCE funds supporting university biomedical and other research on the one hand and on the other research facilities and service support funds supporting the research of the MRC, charities and, indeed, the NHS in hospitals.

Chairman

1285. But concentration on good quality research will surely depend upon the establishment of a good quality assessment exercise, will it not, in the longer term?

(*Professor Peckham*) Yes, it will.

(*Professor Alberti*) I would also add to that, my Lord Chairman, by saying good internal assessment because in these broad exercises you do of course, from a university point of view, spend your time covering the cracks and making sure people do not find out about the bad things that are going on; but internally it is essential you do that. I am not quite as

bullish as my colleagues about the impact of taking R out of one system and putting it back in in a different way. I think it could be a little difficult for some of our teaching hospitals, particularly our provincial teaching hospitals, because the money is embedded in their current expenditure and I think very hard to pull out. I think by eliminating through the sort of mechanisms Steve mentioned, R&D directorates, you can improve things. We are doing things like finally getting pharmaceutical companies to pay proper overheads on hospital-based research as opposed to university-based research. That will help, of course, but I think there is still going to be a rather tough time for a period until people readjust. I think that is a concern and my colleagues in the universities I think share that concern.

Lord Butterfield

1286. I would like to join Lord Perry in saying it has been a very inspiring morning, particularly hearing the way you are facing up to the different challenges. To what extent is the establishment of the "three businesses" going to have an impact on the Culyer deliberations and activities? In other words, do you in your mind's eye, Professor Peckham, see which of the businesses is going to have the big budget and which is going to have the little budget? The other question that I am personally very concerned about is still the current attitude of many managers towards research. We have had just one or two glimmerings in our evidence that there is not a real embracing of research as a prime possibility for making the NHS world leaders in information-based treatment. I must say, I am wondering whether your regional offices are thinking at all of having managers' days to enthuse them with what research is doing for the national status. My Lord Chairman ran a Sub-Committee which found how much research money is coming in from abroad into British science and it is a terrible thing if the people in this country do not realise how much respect our science has in far away places and I just wondered whether managers' research days or something like that—you would probably have to give them a glass of champagne to get them to kick off—might help the overall implementation?

(*Professor Peckham*) By the three businesses I assume you mean the funding of R&D itself, the service support element and research facilities. The task of the new central research and development committee will be to advise me on the apportionment of the budget between the three main elements and they will be introduced on Thursday to what is involved in doing that. It is clear that we will essentially start from a historical position because I am concerned to see that there is stability and that the new arrangements are phased in. We will start from that position and I will be advised by the CRDC on how we develop a more rational basis for distribution.

1287. I am very pleased to hear that because I think the worst thing we can do at the moment is give people in research the feeling that there are going to be dramatic changes and they are going to be made

14 March 1995]

PROFESSOR MICHAEL PECKHAM, SIR MILES IRVING,
PROFESSOR STEPHEN HOLGATE, PROFESSOR GEORGE ALBERTI
AND PROFESSOR ANDREW HAINES

[Continued]

[Lord Butterfield *contd.*]

redundant. I am very glad to hear you are starting from the present position.

(*Professor Peckham*) The second point relates to managers and I believe we have made very substantial progress. I can tell you that the NHS Executive Board at its April meeting will be devoting its entire strategic session to R&D. It is high on the management agenda. It is seen not as a luxurious activity, an ivory tower activity, but an endeavour which really has a major contribution to make, indeed in which there is, in my view—and of course I am totally biased—very little choice. If we want to develop a rationally-based Health Service this is the only way to do it. I believe that that is understood. There is, of course, and your question implies this, a challenge in getting through to management at every level and this is the reason why we have emphasised the development of the R&D networks. Perhaps, my Lord Chairman, colleagues may comment.

(*Professor Haines*) I think it is a very important question. There are a number of ways in which we at regions have tried to build bridges. I think we have begun to make an impact. In our region, for instance, and I think other regions too, we have held courses for managers on critical appraisal. These courses demonstrate how to appraise scientific evidence and how that is relevant to management day-to-day. Secondly, we have tried to involve them very actively in committees, both in the R&D committee and any regional working groups that are taking place, and I think this has paid dividends and now when I go and speak to the chief executives it is quite clear that the majority of them understand what we are trying to do. We try to emphasise that while clinical effectiveness is very important managerial and organisational effectiveness is equally important and that we should not introduce new forms of organising services without testing them as rigorously as we would clinical innovations, and I think that is a message which is beginning to hit home.

(*Professor Alberti*) In practical terms, I meet one a month with the 14 chief executives of the purchasers and amongst other things we talk about research and development, make sure it is in contracts, etc. I meet with the providers fairly regularly and now we are just starting to meet with them together, so the Newcastle Chief Executives of the hospitals and the Chief Executive of the health authority I am taking out for a meal - I hasten to add a cheap meal, no alcohol—to have a discussion about their joint needs because the splitting has been quite harmful. I think we are all aware of it and I think it is working.

Lord Flowers

1288. I understand why a portion of the SIFTR money is not going directly to medical schools in the future and this point has come up already. I think probably the universities will understand this and not mind being in competition with other claimants on that 25 per cent or whatever it is provided they knew that their needs were properly appreciated and taken into account together with others in the allocation of that part of the money. What have you done to make it clear to the universities their needs will be met and

will be taken into account? What mechanism is there for doing that on a continuing basis?

(*Professor Peckham*) We are, of course, conscious of the fact that quality assessment is a central part of this programme. Sir Michael Thompson's review of the postgraduate hospitals in London was a first step, but it is not something that is feasible or desirable to extend nationally both because of the burden on R&D staff and the academic community being subjected to a second review. We are in discussion with the Higher Education Funding Council of England. It is not a simple task to marry up the two assessment exercises. Both sides recognise the challenge of trying to achieve a collaboration and we are moving in that direction. That is important. In terms of involving the universities, we have tried to involve university interests in all aspects of this programme. Indeed, the universities were involved in the appointment of the regional directors of R&D last year and are being involved in taking forward the implementation of Culyer.

Lord Perry of Walton

1289. We are all extremely impressed by the fact that you are all on the side of research and on the side of new entrants. I think what bothers me is that if you look at the situation in Edinburgh, which I did the other day, I think there are 67 people in the teaching hospitals who are classified as senior part-time lecturers by the university. In another enquiry I discovered that they are not paid by the university at all. They are expected to devote two sessions a week to research and teaching that is university controlled, university directed. When it comes to the point, do you not think that whatever you have said, and I am totally sympathetic to it, that managers of trusts might define these calls on the time of staff as something that would go first when the budget gets really tight compared to the care of patients which of course is paramount anyway?

(*Professor Alberti*) It is a continual stress and inevitably it is causing some problems. I think on the other side we do have managers now who want the R&D side of things to work because they see it, if nothing else, bringing more resource into the centre.

1290. I agree.

(*Professor Alberti*) They see that if you have an effective, what we call, A plus B senior lecturer who brings in four research fellows, those four research fellows in fact help with the service. In our own centre we have, in fact, a lot of support to be much more explicit and to start to protect the time of people with those contracts. I think, yes, there are some tensions not so much with the A plus B people but the full-time academic staff where the stresses are much greater and where trying to maintain six sessions a week only is proving most difficult.

1291. I thought A plus B meant some sessions paid by the university, some by the NHS. The people I am talking about are wholly paid by the NHS.

(*Professor Alberti*) We have a situation where there are two university sessions paid for by the NHS or by the university but the NHS have a contract with the university.

14 March 1995]

PROFESSOR MICHAEL PECKHAM, PROFESSOR SIR MILES IRVING,
 PROFESSOR STEPHEN HOLGATE, PROFESSOR GEORGE ALBERTI
 AND PROFESSOR ANDREW HAINES

[Continued]

[Lord Perry of Walton *contd.*]

(*Professor Sir Miles Irving*) Could I comment on this in relation to the University of Manchester. What we have been doing is identifying academics who are no longer research productive and contrasting them with NHS consultants who are research productive and encouraging interchanging of the posts. I think this is a very significant way forward which is welcomed by the trusts. The point of giving honorary titles to NHS consultants such as "honorary senior lecturer" and honorary professorships is to recognise the work they are doing. I think the universities jealously guard these titles.

1292. These were not honorary.

(*Professor Sir Miles Irving*) I am talking about honorary lecturer posts that are given but generally speaking the attitude of the trusts at the present time is that high quality academics are of benefit to the staff and certainly the trusts in Manchester seem to be willing to fund these posts because they are of benefit to them.

Chairman

1293. In relation to what you were saying before about educating the managers you will obviously be concentrating to some extent on the outcome of high quality health services research leading to so-called evidence-based medicine. That has been a very encouraging development but are they also being educated in the crucial importance of bio-medical research and curiosity-driven research which may lead to patient care improvements not next month or next year but in ten years' time?

(*Professor Peckham*) I believe this is a point that has now become fully appreciated. I have emphasised since the beginning of the programme that there are two aspects, relating the Health Service to advances in science and technology, and using scientific methods to address practical Health Service problems. There is another point that in addition to evidence-based medicine we have to move towards evidence-based management and organisation of services. In a sense Miles Irving's Standing Group on Health Technology is a prototype and we are presently considering whether to extend this to encompass issues relating to organisation and management of the NHS in order to focus research in an area of neglect. Could I return to the point about academics because I think it is important. There is a national survey of NHS funding of academic posts, not honorary posts but academic posts, and that will document the totality of NHS funding supporting academic posts. There is an intention to honour that

funding but in future, of course, the sources of funding of research posts will need to be considered in relation to the research funding stream, educational funding stream and, indeed, NHS funds for service posts.

Lord Flowers

1294. I do not feel I got an answer to my question about the university interest and the 25 per cent no longer going directly to them. Professor Peckham said the directors of R&D are nice chaps and know the universities and know what the needs are and it is all very nice and comfortable—except they get captured by the system, if I know anything about posts of this kind. The sort of thing I had in mind was, just as an example, I would be comforted if I knew that 25 per cent was allocated in consultation with the deans of the medical schools concerned. I do not mean they would have a controlling say in the matter but I would at least like to know they were consulted at the final level before the money is allocated, something like that.

(*Professor Peckham*) I note your concern and I note your specific proposal. What I am concerned to do is not make any statement before we release a plan at the end of March/beginning of April. If I may I will take this point you have made away and make sure it is fully addressed.

Lord Gregson] I was very interested to hear several of our friends this morning saying how concerned they are about lack of application of research on a generalised basis. On a recent visit to the States I was told that out-of-date treatment is almost certainly becoming actionable. This is going to carve a great wedge through the whole medical profession. I share your concern but it is wider than just the medical profession. In the physical sciences it was recently said that if you totalled all R&D presently funded by the research councils and used all that money to update British industry the effect on the economy would be quite dramatic. As you all know, that is exactly what the Japanese did. They cut out all original research and devoted the whole of their funds to updating their industry to a point where they are now leading the world and now they can go back and spend some money on original research. In my opinion that is a very serious subject indeed. You may be sitting on a bomb that might explode under you at any time by people suing you for out-of-date treatment.

Chairman] It has been a pleasure to talk to you all and I think we have found it a very fruitful discussion. Thank you so much for coming.

*14 March 1995]**[Continued]***Memorandum by Director of Research and Development, Department of Health**

At my appearance before the Sub-Committee on 14 March time did not permit discussion of some of the issues. The purpose of this submission is to advise the Sub-Committee of steps that are being taken to establish new arrangements for NHS research and development.

CONTEXT

In 1991 when the NHS R&D programme was launched, estimates of existing NHS funds used for R&D were aggregated as a baseline for realising a target expenditure on R&D of 1.5 per cent of the NHS budget by 1997. These resources included a notional percentage of SIFTR, and of SHA funding, funds for the locally organised research scheme and the non-SIFTR scheme. Since then new programmes of work have been resourced or are being commissioned in health technology assessment, mental health, cardiovascular disease and stroke, physical and complex disabilities, primary/secondary care interface, cancer and mother and child health. The Cochrane and York Centres have been established and the basis laid for a research projects database. Other work has been commissioned by Regional Directors of R&D and responsive mode funding throughout the regions has continued. NHS funds have also been used to support research fellowships, training and teaching courses. In 1994 it was estimated that approximately 1.2 per cent of the NHS budget was attributable to R&D.

THE NEED FOR NEW ARRANGEMENTS

By 1993 it had become clear that new arrangements were needed to support the clinical research of the MRC and charities and to fund R&D relevant to the requirements of the NHS. The new arrangements would ensure that resources were used transparently to support high quality work. They would address historical anomalies and introduce new mechanisms appropriate to the rapid progress in medical science and the changing nature of the NHS.

In recognition of these requirements and the opportunities for change, the Minister for Health launched an independent Taskforce, chaired by Professor Anthony Culyer. The main recommendations of the Taskforce for establishing new arrangements were accepted by the Government in December 1994. The key feature is the establishment of a single R&D budget held centrally by the DRD and formed through a levy on purchasers of health care. Initially the budget will be based on existing NHS R&D resources including 25 per cent of SIFTR, the non-SIFTR scheme, SHA R&D, CRDC and regional NHS R&D funds.

USES OF THE R&D BUDGET

The R&D budget will be divided into five categories: research and development, service support, research facilities, information systems and research capacity.

Research and Development

The criteria for NHS research and development were published in "Research for Health"(1993). R&D work directly supported by the NHS includes clinical research, health technology assessment, health services research more generally and public health research. This is predominantly research commissioned on the basis of open competition in relation to clearly defined NHS priorities. A responsive mode funding element has however, been retained.

The future coverage of R&D funding and the means of access to it will be made explicit as the recommendations of the Taskforce are implemented. Care will be taken to ensure that the funding streams for research and development, service support and research facilities together continue to sustain the full range of activities which the NHS currently supports and which are needed by the NHS and the research funding bodies with which it works.

A plan which integrates NHS R&D staff in regional offices and the NHS Executive in Leeds is being prepared. As part of the process the distinction between national and regional R&D priorities will be reviewed together with a detailed reappraisal through the CRDC of the mechanisms and criteria for establishing priorities for Research and Development.

Service Support

The excess service costs of MRC, charity and NHS research will be identified and met as simply as possible. The criteria for service support and the mechanisms for allocation will be published well in advance of the establishment of the single levy in 1996. Anxieties have been expressed that because of a possible dilution of service support funds, major academic centres might be compromised through the new arrangements. It is argued that such a threat might arise from the extension of service support funding to non-academic hospitals

*14 March 1995]**[Continued]*

and primary care and from an increase in the volume of research making a call on service support funds. However, this concern is ill-founded. The purpose of the new arrangements is to ensure that the service support element of funding will cover clearly established needs. If there is a convincing case for augmenting this element of R&D funding, additional funds will be sought. This was recognised in the Secretary of State's announcement of additional funding for NHS R&D on 22 November 1994. Funds required to support the excess service costs of high quality clinical research have never been quantified. There is a dual challenge for the academic community working in conjunction with NHS R&D staff. A first task is to make a realistic assessment of service support requirements. A second and related task is to ensure that poor quality research no longer makes a call on service support funds. Unquantified funds currently devoted to R&D in NHS hospitals and general practice also need to be identified, protected and used to build up the central R&D budget. Guidelines for achieving this will be issued in 1995.

Extension of service support into primary care will not be a rapid process and academic centres have an important role to play in helping to strengthen the clinical research base of primary care.

It would be regrettable if biomedical research and applied health research were regarded as being in competition. The skills of academic medicine are essential for the clinical exploitation of advances in basic science. The skills of applied health research are needed to assess and implement innovations in patient care. An imbalance between biomedical research and health services research would be likely to weaken both. Academic centres should lead the way in demonstrating the advantages of developing both in tandem.

Research Facilities Support

The purpose of research facilities funding is to provide support for the costs of facilities and staff which cannot reasonably be attributed specifically to individual research projects. The announcement on 15 December makes it clear that research facilities funding are designed to ensure the long term support of research and development. The arrangements will ensure that facilities funds are used for the programme for which they are designed. The purpose of the new arrangements is to move away from subsidies to the transparent allocation of funds based on clearly defined contracts. Details of these arrangements will be published following wide ranging discussion. The aim is to devise a simple and workable system for allocating research funds.

Research assessment

The extension nationally of the approach adopted in the Thompson Review of the London Postgraduate Hospitals is neither desirable nor feasible. It would subject the academic community to a major additional review other than the HEFCE research assessment exercise and also involve R & D staff in an excessive of further work. However, valuable principles have been established by the Thompson Review with lessons learnt for future practice. Initial discussions have taken place with the HEFCE to explore common ground between their research assessment exercise and the requirements of the NHS. These will continue.

IMPLEMENTING THE NEW ARRANGEMENTS FOR SUPPORTING R&D IN THE NHS

The reconstituted CRDC met for the first time on 16 March and the new National Forum will meet on 25 May. Plans for implementation will be published in the near future, these will set a detailed time table and describe the structure by which the new arrangements will be set in place. There will be ample opportunity for academic and university input and transparency in working up the detail of the new arrangements and making clear the mechanisms by which they will operate.

REGIONAL R&D

R&D has emerged from the Functions and Manpower Review of the NHS considerably strengthened. It is a core function of regional offices in which the RDRD is a member of the senior executive team. RDRDs therefore have the authority and resources to develop and sustain a long term view as well as to deliver on short term issues. It is an integral part of the R & D role to safeguard the longer term interests of research conducted in or in association with the NHS. It is also an essential function to see that practical NHS problems are tackled through well conceived proposals of applied research. RDRDs must enjoy the confidence of the research community. They must also enjoy the confidence of NHS medical and non-medical staff, public health physicians, managers, patients and the public. This is essentially a new role for the research community. Relating to and having the confidence of these constituencies is essential for the success of the NHS R & D programme. Academic and university interests have been involved regionally and centrally since the inception of the programme. In the first round of RDRD appointments to the Regional Offices in 1994, for example, Sir Leslie Turnberg, President of the Royal College of Physicians and Sir Michael Thompson, Vice-Chancellor of the University of Birmingham served as external assessors. Regional Directors will obviously wish to take account of the views of the Universities when making new RDRD appointments. The

14 March 1995]

[Continued

first such appointment will be the replacement for Professor Alexander McNeish who leaves the RDRD post in West Midlands to become Director of the MRC Clinical Research Centre at Hammersmith. Sir Michael Thompson will participate in the appointment.

REFERRAL OF PATIENTS

Recognition by Ministers of the need for synergy between patient care and research was the point of departure for establishing the Taskforce chaired by Professor Culyer. Patient referrals should take into account agreed long term strategies for the major providers of research but at the same time the development of research providers cannot be dissociated from the changes in the organisation of the NHS. Ministers have made it clear that they wish to aim as far as possible for stability in hospitals funding and for managed implementation of any necessary change. The issue of patient referrals and research will be considered in detail as part of the implementation of the new arrangements for supporting R & D in the NHS.

THE MRC CONCORDAT AND RELATIONSHIP WITH CHARITIES

The current Concordat with the MRC recognises that as another Government funded body, the relationship with the health department is special. The annual stocktaking meeting has recently been held and plans are now in hand to review the progress of the Concordat since 1992 in time for its renegotiation in the Spring of 1996. The new Concordat will build on the very real achievements of current arrangements. However there are several areas where there is scope for positive change. First, the distinctive contributions of MRC and NHS research need to be defined more clearly. Second, the NHS should become increasingly familiar with the basic science as well as the applied research portfolios of the MRC. Third, although substantial progress has been made in presenting well characterised health problems to the MRC, further advances can be made in this domain.

At the same time we have been developing our relationships with other major research funders including AMRC, the Wellcome Trust and other major charities. The AMRC's executive council have recently sent me a draft set of principles designed to lead to an agreement between the Department of Health and the AMRC. We will be considering these very positively in the light of work on Culyer implementation and I regard this as a first step in developing closer relationships between the NHS and the charities. We have also established concordats with the EPSRC, BBSRC and an agreement with ESRC. The National Forum which meets for the first time on 25 May provides a new mechanism for discussing issues of common interest to all funders involved with the NHS.

Further memorandum by the Department of Health

Question 1: *Please provide a thumbnail sketch of the original Oxford "GRiP" initiative: what did it actually involve?*

1. The systematic transfer and uptake of research information into the NHS is being pursued in a number of initiatives. These include the introduction of research evidence into purchaser-provider contracts (GRiP is an example) the use of guidelines and protocols and information leaflets for patients and the public. Emphasis is also being given to R&D based clinical practice. An example is the Centre for Evidence-Based Practice in the Nuffield Department of Medicine in Oxford.
2. Getting Research into Practice (GRiP) was launched in the Oxford Region in May 1993 to identify ways in which health authorities could use research evidence to influence purchasing. The projects undertaken within the GRiP initiative are being taken forward in each of the four health authorities. For each of the projects there is research evidence relating to effectiveness. The projects include: corticosteroids in pre-term delivery (Oxfordshire); dilation and curettage in women under forty (Buckinghamshire); surgery for children with suspected glue ear (Berkshire) and services for stroke patients (Northamptonshire).
3. Workshops were designed to assist staff to understand and acquire the necessary skills to appraise research reviews critically, and to draw conclusions about the reliability, results and relevance of individual reviews.
4. The four health authorities were offered a range of issues, those selected took account of local concerns. The RHA, and subsequently the NHS Executive, provided funds so that the experience gained from the GRiP project could be extended more widely.
5. Similar processes were adopted in each of the four authorities. Each project started with detailed work involving purchasers, providers and GPs. The purpose was to gain an understanding of the available evidence, of current practice and treatment on offer. This provided a basis for the development of local policy and/or protocols which then became the standards against which performance can be monitored through clinical audit.

14 March 1995]

[Continued

6. The purchasing function provided the initial focus of the work. Attention has subsequently been directed to exploring how health authorities can help GPs to handle, and patients to understand, the changes that are being introduced.

Question 2: *Please provide a note on "education consortia" as envisaged under the Health Authorities Bill.*

1. Workforce planning and determining intake levels to education and training programmes will be primarily an employer responsibility. Purchasers of health care will also have an influence, especially as they develop longer-term strategic purchasing plans. Purchasers, NHS health care providers, GPs and non-NHS health care providers will join together in consortia to determine the level of student intakes. As soon as practicable, consortia will take responsibility for holding NMET budgets, commissioning NMET and thus contracting with education providers;
2. The number and size of consortia will depend on local circumstances. Consortia may be based on geographical patches and/or relate to one or more major education providers. There is no central prescription on this and ROs should, in consultation with local interests, determine a pattern of consortia which embraces NHS and non-NHS bodies within their geographical boundaries. There is no presumption that consortia are obliged to contract with any particular education provider but consortia will have to honour inherited education contracts and, in the context of creating a suitably competitive environment, will wish to weigh carefully the benefits of longer term relationships with particular providers.
3. Membership of a consortium should include:
 - a representative of each Trust;
 - a representative of each NHS purchasing authority;
 - representatives of GPs, including GP Fundholders;
 - a representative of each Social Services authority; and
 - representatives of the non-NHS public sector and the independent and voluntary sectors.
4. Each consortium will identify a chairperson (subject to the approval of the Regional Director), who need not be the consortium's representative on the REDG.
5. It is acknowledged that some Trusts—for example Ambulance Trusts—may have little interest in commissioning health care professional education. Their main interest will lie in consortia activities related to management, organisational and personal development. Consortia membership arrangements may take account of this by, for example, allowing for membership of sub-groups only. Participation by non-NHS bodies is entirely voluntary but every effort should be made to encourage the independent and voluntary sectors to contribute to consortia working.
6. Consortia will have three main functions:
 - collating workforce plans prepared by constituent members and turning this into an expression of demand for newly-qualified staff at a future date. After allowing for wastage during training, this will become the proposed level of student intakes for the coming year, with estimates for the next three years in the context of service provider five year business plans. Consortia must take full account of the demand for newly-qualified staff from outside the Hospital and Community Health Service (HCHS) because the crude wastage rate from the HCHS will prove an increasingly unreliable guide to demand in primary care and in the independent and voluntary sectors;
 - consortia will increasingly commission education direct from education providers. For this purpose they will need to be operational budget-holders. This will enable them to influence not only numbers, but also quality, admission policies and "fitness for purpose";
 - consortia, working through the REDG, will provide advice on the numbers and types of doctors needed and on the local arrangements for PGMDE. Postgraduate Deans will play a key role in ensuring that this advice is taken into account in the implementation of national initiatives and in the development of national policies and workforce planning.
7. Consortia will not be legal entities, will not be allocated separate funds to cover their own running costs and will not employ staff. Subject to Parliamentary approval, the Secretary of State will have powers to direct NHS bodies to work together in consortia for education and training purposes. One of those bodies will need to employ the staff needed to support the consortium's work and to manage devolved budgets.

Question 3: *What bodies are to be subsumed within AGMETS? Will AGMETS subsume either MMSAC or SCOPME?*

1. The Advisory Group on Medical and Dental Education, Training and Staffing (AGMETS) was set up with Ministerial agreement when it became clear that a single body was needed to oversee all workforce issues; AGMETS is supported by a simplified and streamlined advisory structure. It first met in December 1994. It has replaced the overlapping committee structures which advised on medical staffing policies (*Achieving a Balance*, which seeks to ensure an adequate supply of

14 March 1995]

[Continued

appropriately-trained doctors in each specialty, and the *New Deal* to reduce the hours worked by junior doctors). It will also oversee the implementation of *Hospital Doctors: Training for the Future*, which recommends shortening medical and dental higher specialist training.

2. The Medical Manpower Standing Advisory Committee (MMSAC), which has now been re-named the Medical Workforce Standing Advisory Committee (MWSAC), and the Standing Committee on Postgraduate Medical Education (SCOPME) have not been subsumed within this new committee structure. SCOPME have a representative as an observer on AGMETS. Both committees may submit papers to AGMETS on relevant issues.

Question 4: For the purposes of pulling together the "single funding stream for R&D", are the hospital research endowments considered as NHS R&D funds, or external funds?

1. Hospital research endowments are external funds, and as non-Exchequer funds, will not be a part of the "single funding stream for R&D".

Letter from the Department of Health

Please find below the answer to your recent question on whether dental SIFTR is going to be part of the funding stream.

There is no consensus on the size of the research element of dental SIFTR, except that it is considerably less than the 25 per cent attributed to medical SIFTR. The research element of dental SIFTR will therefore not be included in the initial R&D levy established on 1 April 1996. Dental hospitals will however be asked, along with other NHS providers, to declare their R&D expenditure so that it can be added to the full R&D levy on 1 April 1997."

Trish Fretten
Parliamentary Clerk

12 April 1995

Examination of witnesses

PROFESSOR J A KENNERLEY, Chairman, MR PETER BURLEY, Acting Registrar, the Council for Professions Supplementary to Medicine, DR JEAN POTTS, Chairman, Physiotherapists Board, and DR PAM ENDERBY, Chairman, College of Speech and Language Therapists, were called in and examined.

Chairman

1295. Thank you for agreeing to come and talk to us. How many professions are represented on your Council and will you tell us about the Council and its research-related activities?

(Mr Burley) The first thing I need to say, my Lord Chairman, is CPSM is not an umbrella representational body. What we do, though, is liaise with a group called the Health and Care Professions Education Forum on matters of mutual interest such as research. This is why we are able to appear before you with a delegation of four people whom I hope will be able to do justice to your questions and answer any queries that come up. The Chairman and I will defer to them for most of the detailed answers to your questions. Before you, you have myself as the Acting Registrar at CPSM; Professor Kennerley, who is the Chairman; Dr Pam Enderby who appears here through the good offices of the Health and Care Professions Education Forum and she is Chairman of the College of Speech and Language Therapists and also President of the Society for Research and Rehabilitation; and Doctor Jean Potts on my left is the Chairman of the Physiotherapists Board and is Deputy Head of Department, Institute of Health Sciences at the University of Northumbria at Newcastle. To answer your question of who we are and our professions, there are currently seven

professions which are designated "professions supplementary to medicine" which provide essential support to the health services and they are: chiropody, dietetics, medical laboratory sciences, occupational therapy, orthoptics, physiotherapy and radiography and we are expecting an Order shortly to bring arts therapists and orthotists and prosthetists also into our Act.

1296. Forgive me, you did not mention speech.

(Professor Kennerley) No, the interesting part is that we liaise very closely with the College of Speech and Language Therapists, and we are very delighted to have them with us today but in a sense we are not representative of any. Speech and language therapists are not designated as a profession supplementary to medicine.

1297. I wanted to be clear on that particular point because the documents you sent us dealt essentially with the interests of people working in the field of speech and language, physiotherapy and occupational therapy but there was no comment in the evidence you sent in relation to, for instance, dietetics, medical laboratory sciences and so on. Are you then able, in a sense, to speak to this Committee on behalf of all of those groups?

(Professor Kennerley) Strictly no, because it depends on the professional bodies. What we can give is an overview but we have invited two

14 March 1995]

PROFESSOR J A KENNERLEY, MR PETER BURLEY
DR JEAN POTTS AND DR PAM ENDERBY

[Continued]

[Chairman contd.]

representatives, one of whom, Dr Potts, is a physiotherapist and one is one of our colleagues not under the umbrella of the CPSM in the form of Pam Enderby.

1298. Thank you for clarifying the position.

(Mr Burley) The Council for Professions Supplementary to Medicine and the Boards under its aegis are a federal structure and we were established by the Professions Supplementary to Medicine Act 1960. The Boards are independent statutory state registration bodies and each profession is regulated by a Board, the majority of whose members are elected directly from the profession. State registration is a universal "kitemark" for the protection of the general public as a guarantee of competence at the time of registration. State registration is also a requirement for employment in the National Health Service, including trusts, and in local authorities for social services functions. The Boards and Council ensure standards of education, training and discipline of the qualified practitioners in these professions and the Council and the staff at CPSM act as an enabling and facilitating framework for the work of the Boards. On research specifically, the Boards and Council have two statutory interests. Under Section 1 of our Act the Boards have, "... the general function of promoting high standards of professional education" and then under Section 4(1)(c) of our Act: "The Boards are required to decide on the suitability of institutions for the delivery of education and training in the professions." The Boards have deemed that a sound research base is an important part of that judgement. This is a significant view because it confirms the development and maturity of the professions and their proper place in the medical family—that was a term used during the preparation of our Act during the 1950s. The Boards' general concern is two-fold. First the arrangements made by the NHS must create a level playing field where all professions and all universities have fair and equal access to funds and applications are judged on their merits. Second, smaller professions must be able to get a foot on to this ladder and their newness to the research community must not be used as an argument in itself to exclude them from it. The Council and Boards themselves do not at present have a direct research capacity, but the Act does allow such activities to be sponsored by them. We would be very interested in recommendations which arose from this Committee's work which might want to look again at these powers. The Boards at CPSM have ownership of the state registered standard and that encompasses the competence to practise and the disciplinary standard of the professions. The professional bodies have ownership of the ethics and knowledge base of the professions and that is why the link with the professional bodies is so important in the context of our delegation today. We work as a mutually supportive partnership, and appear before you in that capacity.

1299. Thank you. It is the case, is it not, that the government have announced that they are about to review the Act under which you exist, no doubt a process which will take some little time.

(Professor Kennerley) It is indeed. Can I elaborate and give a little flavour to that introduction. The first duty of the CPSM is to create safe and competent practitioners for the benefit of the public. We do that through monitoring and assisting the activities of the Boards to validate and inspect courses and so on. We are concerned with state registration and the standards and perhaps, looking at research, I can link it with another hat I wear which is as a chairman of a health authority, and say that with respect to the professions supplementary to medicine and some of the other professions such as speech and language therapies, they are in a sense relatively new professions compared with the medical professions and, of course, they have only recently become (and largely are now) degree professions in establishing their own bodies of research and knowledge inside their professions. I think sometimes the professions are put in a little bit of a Catch 22 situation in that looking at research requirements they make applications for funding and sometimes they are asked, "What is your track record?" and of course there is not much of a track record at the present time. I think that is one of the problems our professions face. The second thing is following the reforms we do have actual movement towards primary care, we have movement towards trying to provide care in the community and so on. I think there is a belief, and I would support that belief, that a lot of benefit is accruing to patients and there is patient health gain by work very much done by the professionals that we have mentioned in the community and so on. What would be of great benefit is if somewhere in your Lordships' document there were recommendations to the effect that research should be done in those sorts of areas probably multi-disciplinary, but also sometimes unidisciplinary within, say, physiotherapy, or occupational therapy or speech therapy, to demonstrate some of those benefits which it is beginning to be believed are enacted by practice in the community and at home. Those are the sorts of comments I would like to lay before members of your Committee, sir, before we get into detailed questions.

1300. Perhaps you could tell us about areas of scientific advance in research in areas of interest not only to the professions who are represented today, and tell us where are the centres of excellence.

(Dr Potts) My Lord Chairman, most of my comments will be particularly related to physiotherapy, although I will refer to speech and language therapy as well. First of all, in terms of scientific advances I would say that the scientific advances that have the most impact on physiotherapy, and I would say the other professions as well, are the development of more valid and reliable tools of investigation and also ways of measuring outcomes of therapy. For example in relation to physiotherapy, technological advances have enabled us to look more carefully at ways of measuring and assessing activities like walking, muscle strength, joint mobility and electrical activity of muscles, and also to look more generally at functional abilities. These methods of investigation have thus enabled us to look more critically and start to evaluate the outcomes of particular therapeutic

14 March 1995]

PROFESSOR J A KENNERLEY, MR PETER BURLEY
DR JEAN POTTS AND DR PAM ENDERBY

[Continued]

[Chairman *contd.*]

interventions. I thought it would be useful if I gave you a list of some of the areas in which physiotherapists have been conducting research and publishing in major scientific journals: pain management, particularly in relation to looking at effects of physiotherapy interventions like laser therapy and transcutaneous nervous stimulation; another area very high on the physiotherapists' agenda is looking at stroke rehabilitation and starting to look at what the different therapeutic approaches are and what are the values of the particular therapeutic interventions; muscle strengthening regimes, which I mentioned before, and expanding that to look into the whole area of fitness and quality of life and health promotion; physiotherapists have been investigating incontinence (that is a particular area of specialty at Bradford); respiratory functions has also been an area that has been researched; management of the elderly; management of children with special needs; physical and complex disability. Even though we are a relatively new profession, over the past ten to 15 years, there has been quite an upsurge in published credible academic research in these areas. In terms of centres of excellence I would divide those into two categories; the traditional medically-led centres of excellence which tend to be associated with the teaching hospitals and medical schools; and the other centres are those which tend to be led by therapists and are linked more with higher education establishments, particularly the newer universities. The medically-led centres include the Rheumatology and Rehabilitation Research Unit of the University of Leeds. Professor Anne Chamberlain leads this unit and this involves not only physiotherapists but members from all professional groups. It is a genuine multi-disciplinary research centre and others—the City Hospital in Nottingham with its Stroke Research Unit; again this is a multidisciplinary research centre and similarly the Norwich Park Hospital Regional Rehabilitation Unit. I would like to mention (I am biased because I come from Newcastle) the Newcastle Hunters Moor Regional Rehabilitation Centre, which is certainly developing its profile, again not just in physiotherapy but multi-disciplinary. There is the Oxford Rivermead Rehabilitation Centre and the Nuffield Orthopaedic Centre, which has its own physiotherapy research division. Southampton University, which is led by Professor McLellan, is a very strong multi-disciplinary rehabilitation centre. We have got the Royal National Hospital for Rheumatic Diseases in Bath. In Bradford we have the Urology Department, where Dr Jo Laycock specialises in the field of incontinence, looking at physiotherapy methods in that area. I think it is important to emphasise in relation to the therapy-led centres with the increase now of the all-graduate professions and the newer universities coming on to the scene, that a number of us were successful in the last research assessment exercise in obtaining a quality rating of two which is pretty good, I think, for new professions like physiotherapy and speech therapy. King's College London, which is not a new university, has a Physiotherapy Research Group which is led by Professor Di Newnham. Again that is good; we have now got professors of physiotherapy and their

particular area is investigating neuro-muscular and musculo-skeletal disorders. The Salford College of Technology, which is a new university, also includes occupational therapy, podiatry as well as physiotherapy, and they were successful in obtaining a research rating. Queen Margaret College in Edinburgh, which has got dietetics, podiatry, physiotherapy, occupational therapy and speech therapy, was successful in obtaining a research rating. From my own university, and own department we have a Therapeutic Studies Division which includes occupational therapists as well as physiotherapists. We were successful in obtaining a research rating. Even though we are a small unit our specialty area is investigating movement disorders, not only stroke but looking at schizophrenia and Parkinson's disorders, community physiotherapy and models of practice. There are newer centres developing which hopefully will be successful in the next research assessment exercise, such as Ulster University with its bio-therapeutic centre and it specialises particularly in looking at physiotherapy interventions in the management of pain. Glasgow Caledonian University, which has now got a research centre, is physically based in a hospital. That is a model that is starting to be perpetuated where you have got close co-operation between the trusts and the universities working hand in hand in developing research. Sheffield Hallam focuses on stroke outcomes. Brighton, West London and the University of East London each have got their own physiotherapy research units and multi-disciplinary research units. Could I add that all the universities who have now got health care professional courses established there, are developing research centres. We have got 12 universities with speech and language therapy. I think I am right in saying there is only one independent research unit, which Pam is actually heading, at the Frenchay Hospital and because of funding situations that unit is particularly vulnerable.

1301. Thank you very much. No doubt, of course, physiotherapists are also involved in the developing field of sports medicine too.

(Dr Potts) Absolutely.

1302. Which has established one or two centres of research in the United Kingdom.

(Dr Potts) Yes.

Lord Butterfield

1303. In China in the morning you see many old people doing all kinds of extraordinary exercises. When are we going to get from you physiotherapists a little handbook for those aged 60+ on exercise?

(Dr Potts) That is question seven, opportunities for research, looking at different approaches. I forgot to mention acupuncture but acupuncture is certainly something investigated by physiotherapists and, yes, we will be starting to look at tai chi and other approaches to health care management.

14 March 1995]

PROFESSOR J A KENNERLEY, MR PETER BURLEY
DR JEAN POTTS AND DR PAM ENDERBY

[Continued]

Chairman

1304. Now, Dr Enderby. I should just mention in passing that as a neurologist I did some work years ago with Dr Muriel Morley and later with Dr Ruth Lesser so I know something about your field.

(Dr Enderby) I may appear as if I am going to be the Jeremiah amongst the bunch today, I am afraid. This is not because I am by nature a pessimist but I realise we are extremely short of time. You will have heard a great deal of optimism and enthusiasm from the previous presentations and what I would like to do is perhaps draw your attention to some of the difficulties that are happening now in the field. I would like to put that in the context of the fact that the professions in which I am involved are particularly keen on the Peckham initiative. They applaud and appreciate the way that it is going forward. There are some problems, however, for us and they come under four headings. I would first of all like to look at structure, then career, then education and then dissemination if I may. The structure, of course, is ruled by the Central Research and Development Council and then through the regional R&D directorates. We have been concerned that there is no broad representation on the CRDC. Whilst, of course, they do ask for certain opinions those requests are not necessarily channelled through the professional bodies. Sometimes they are channelled through somebody happening to know a speech and language therapist and it is not officially fed through the right structures. Unfortunately we have not been asked to comment or be involved in some programmes or areas of work that directly affect us or to which we could contribute. The relationships between the therapists and regional R&D directorates depend very much on personalities. There are some regions that do appreciate the role of therapists and others in health care; others unfortunately do not and there is a great concern amongst the professions within the Society for Rehabilitation that there appears to be a degree of *ad hoc-ism* with regard to who is asked to comment or be involved in what. If I can go briefly then onto the career structure. This was always difficult for therapists who wanted to pursue research and has become more difficult given the changes in the NHS. Some of this is because, of course, many trusts now want their therapists to be very much hands on most of the time with their patients and have taken out of job descriptions in many cases any element of being allowed to develop or spend time on research. That is seen really as an extra or a jam on the bread and that is being excluded to some extent. So we have a problem with young therapists being allowed time to show interest and develop or participate in research within the NHS. We have, of course, a problem of infrastructure. You will have heard from other people I am sure of the difficulties with trusts trying to attribute costs for different services aspects and it is difficult for therapists now to have access to the infrastructure which would support some research that would go along with their clinical work. Most of the clinical therapists are asked to be clinicians only. There are very few posts and certainly I am unaware of any that have a specialised research component to them that is funded by the NHS. If I may, my Lord, give you an example of my own position which was perhaps at the opposite end. I had become a district

therapy manager and I had one third clinical time, one third management time and one third research. As with many trusts those senior positions have gone which has, of course, left the therapy professions in a very difficult situation because there is no career opportunities if they want to stay within their own profession. It left me with the challenge of what do I do at this ripe old age I have attained and wanting to stay within my job. The only opportunity I had was to go on to soft monies, to go out and get grants to do research within my field that I know needs to be done. This means that I am now on a three-month short-term contract as are the colleagues that I work with and try to get support for. I am not unusual my Lord; there are many people who are faced with the position of what do we do within the NHS to stay within our careers and maintain good research developments for our professions and ultimately, of course, for the benefit of our clients. The third point is education. At the under-graduate level it is not clear how the changes highlighted by the Culyer report are going to assist any of the non-medical disciplines related within the Health Service. It is still quite difficult to ensure that the under-graduate training of therapists truly integrates into the NHS programme and helps with increasing the work performance from a cognisance with research methodology. On the post-graduate side there are now many regions who which fund one or two masters places, MPhil places, but we are talking maybe in the south west two research fellowships for the whole of the south west for all of the therapy professions.

1305. And PhDs?

(Dr Enderby) These would be for MPhil's or PhDs. There is a lot of competition, as you can imagine, for those places. There are other supports but they are very very small and very sought after. It means that physiotherapists are competing against speech therapists and occupational therapists.

1306. From what source did you get the soft monies to support your own research?

(Dr Enderby) I have received one grant from the Department of Health, central monies, not from the Peckham initiative. I have monies from the Nuffield Foundation and British Telecom. If I may go on then. The post-doctoral monies that are available for therapists are very small indeed and tend to be related to charitable giving. Some charities do support post-doctoral work of the therapists, again these are small and very competitive. There are some regions that are now looking at making post doctoral appointments of therapists but I am only aware of two regions that are doing this and we talking about one or two places. If we stick in the broader area of education, something such as accessibility to libraries and journals relevant to therapists is challenging and almost impossible in some areas. This is something that is probably too low level for your consideration but it is something we see every day; our therapists are unable to get access to the journals which are representing the papers that we are struggling to publish.

1307. Nothing that deals in any way with research in the NHS is beneath our consideration; we are looking at the whole field.

14 March 1995]

PROFESSOR J A KENNERLEY, MR PETER BURLEY
DR JEAN POTTS AND DR PAM ENDERBY

[Continued]

[Chairman *contd.*]

(Dr Enderby) Thank you, Chairman. The last area I mentioned was dissemination. Certainly the professions were stimulated by the Peckham documents and we realised we had been guilty in not disseminating much of the research that we were actually developing ourselves. Most of the colleges have improved this so that our own professions are more familiar with what is being learnt. You will have heard about the NHS register of research projects. You are probably not aware that the majority of therapy research is unable to be put on that register because 70 per cent of our research is not funded by NHS monies; it is funded by charities or other organisations.

1308. We have been told, perhaps wrongly, that all research that is being conducted in the NHS may be included.

(Dr Enderby) That is incorrect, I am afraid.

1309.—certainly as far as medical research is concerned. Medical research conducted by charities is an enormous amount of research.

(Dr Enderby) My understanding is that even medical research funded by charities at the moment is not going on. I have been in touch with the register as of two weeks' ago to see whether we could look at getting charity supported work by therapists on the register. It is of great concern to us because it gives the appearance that therapists are not doing the amount of research that they are. At the moment we were advised directly from the register—

1310. We have been told that at the moment the register is simply NHS funded research but that the intention is to extend it to include all research carried out in the NHS.

(Dr Enderby) We hope so.

Lord Butterfield

1311. Perhaps the register could make that point in compiling the list?

(Dr Enderby) Two other things under dissemination. One is the Cochrane initiative, an initiative which is to be applauded and certainly I have been actively involved in this. Of course that type of systematic review lends itself very much to medical research. It does not necessarily lend itself to reviewing the other types of methodology that underpin different types of research. We do hope in the fullness of time that we will be able to see systematic reviews of credit that are appropriate for our subjects but at the present time there is an appearance that certain methodologies are either second rate or inappropriate. I would draw your attention to the fact that there are some methodologies, social or educational methodologies, that are appropriate for some questions and at the present time we are having a little difficulty in getting that accepted by some of our medical colleagues.

Chairman

1312. It is the case, is it not, that many of the professions on whose behalf you are speaking today are involved in collaborative research with people in a series of medical specialties such as rheumatology

and rehabilitation and so on. Of course, you are concentrating in particular on research which you are carrying out as individuals or groups within your own professions.

(Dr Enderby) No, I think both ways. Frequently we collaborate and we are extremely pleased to do so. Sometimes it has to be uni-professional research and sometimes we might wish to lead research and have other disciplines, including medicine, being the collaborator, that way round.

1313. Just to clarify what you said to us before, you receive a grant from the Department of Health, not you say from R&D money but presumably from what the Department of Health calls the small grants division?

(Dr Enderby) No, this is from the policy division.

1314. And also of course funding from other charitable organisations?

(Dr Enderby) Yes.

1315. You did say also that there were opportunities for MSc studentships and a limited number of PhD studentships funded from NHS money at regional level.

(Dr Enderby) And nationally.

1316. There is some money?

(Dr Enderby) Yes.

Chairman] I presume those would be a charge on the R&D budget.

Lord Perry of Walton

1317. Do you get money from LORS?

(Dr Enderby) Yes, we have been fortunate in receiving grants for certain projects under LORS and some from the regional R&D programmes of work as well.

1318. Do you look on that with more optimism than you do on some of the others?

(Dr Enderby) I look with optimism on anything that might give me money, my Lord!

Chairman

1319. That is a fairly common attitude! I think you have really answered the R&D strategy question and your response to Culyer; you wish to see all of the professions with which you are concerned having access to funds under this kind of approach. The Department of Health is currently examining capacity in research encompassed by non-medical disciplines. Are you making representations and what would you like to see done?

(Dr Potts) I will answer that one but could I go back to the other question, R&D and the Culyer report. What I have been informed by the Chartered Society of Physiotherapy is that the Physiotherapy Society and other colleges have expressed a commitment and willingness to be involved in this initiative, but as yet they have not been invited or consulted. So there is a genuine willingness to be involved. If I could go back to the R&D strategy, whereas Pam might feel like Jeremiah I think I have been brought in as the positive person and I think it is worth highlighting the opportunities that the NHS

14 March 1995]

PROFESSOR J A KENNERLEY, MR PETER BURLEY
DR JEAN POTTS AND DR PAM ENDERBY

[Continued

[Chairman *contd.*]

R&D strategy has provided particularly to the professions allied to medicine. I am going to use as an example of good practice some of the changes that have been going on within the northern region and also the Yorkshire region. First of all, I think that R&D has developed a higher profile within the NHS particularly in terms of raising the awareness of purchasers and providers. One of the benefits that we have certainly found in raising the awareness of purchasers is they are now, certainly in the northern region, not just thinking of medical schools and medical staff leading research grants, they are wanting to involve the therapy representatives. For example, one of the newest initiatives is that one of our trusts is actually seeking to fund an physiotherapy chair (and it will not just stop there, it is also thinking about funding other professorial appointments) because of their commitment to developing research not so much in the profession itself but developing the service to patients and clients. Thus the trusts are wanting to set up their own centres but with appointments that will be university-based but essentially for helping to improve the service. Within the northern region professions allied to medicine were involved in their main R&D committee. They were also invited to serve on all of the specialist task groups. We also set up a nursing midwifery and professions allied to a medicine standing advisory committee which still reports directly to the directors of R&D. I think that is an example of good practice. The region has also taken a lead and funded, admittedly not many, but certainly more than one research assistants, research training fellowships and PhD studentships within each of the universities in the northern region. In the Yorkshire region they have invested a considerable amount of money in setting up research training courses for all the health care professions. Before the R&D strategy we never had that sort of drive. Now we have that drive and that has given us an opportunity to raise our profile. We want it to continue and our fear with the Culyer report is, yes, we have achieved a lot but what we want to see in the Culyer report is a recognition that the professions allied to medicine want to work hand in hand with nursing and medical colleagues to implement the recommendations. The recommendation that we were particularly pleased with and wanted to see developed further is the one concerned with developing a human resource strategy for R&D in the NHS embracing training and more general personnel issues. I support Pam's comments about research training. On the one hand I am presenting a positive view but I know that in practice many of our universities, for example, have set up and developed post-graduate research training taught MSC courses yet practitioners in the field are having considerable difficulty in getting the time off and funding to go on those courses.

1320. Are those MSc taught courses whole time for a year or part time for two years?

(Dr Potts) Part time over two years or full time over one.

Lord Perry of Walton

1321. I have got no idea of the sort of numbers in each of your professions. Could you let us have a very short note?

(Mr Burley) We have 93,000 current registrants altogether; 25,000 are physiotherapists and then the numbers go down to 1,000 orthoptists but we will submit that in writing to you.

Chairman

1322. It would be helpful to have that information and also some indication from the Speech and Language Therapists.

(Dr Enderby) We have 6,500 members.

1323. I know the other professions—physiotherapy, occupational therapy—have moved rapidly towards an all graduate profession but yours has been all graduate for some time?

(Dr Enderby) That is correct.

(Professor Kennerley) Can I make a comment, Chairman to conclude. It was with great interest we heard the previous group with Professor Peckham. I think it is fair to say his research developments have actually been very welcome in that he has developed the development side enormously. He has actually communicated with trusts, with purchasers (because I am one myself) and done a great deal to bring to managers the interests and value of the researches being done. He has pointed the research to wards more practical and pragmatic areas. Where we would want to give it a little nudge is to recognise the potential value of the work done by the therapists and it should be properly researched and that gain and benefit could be identified and disseminated.

(Dr Potts) There was one point I was asked to make and that was in relation to the Culyer report. There is a reference to the pre-protocol curiosity-driven research which is going to be up to the purchasers, the trusts, to fund. I think we felt some concern about that because pre-protocol curiosity-driven research is extremely valid in changing and developing practice and our fear is that if this type of research, which is so valuable for the neuro-professions, is not going to be funded and has to rely on funding from R&D trust funding, I think it will not get much support because of competing demands on the funding of the service.

Lord Perry of Walton] Do we not feel this is one of the things LORS will in fact be used for and that was the whole idea?

Chairman

1324. We have been assured this morning that the locally operated research schemes (LORS) will continue.

(Dr Potts) May I add two points?

1325. By all means.

(Dr Potts) I think we have to emphasise the challenge of community care, the challenge that will bring not just to general practitioners and nursing staff but particularly to the professions allied to medicine. I think also we as therapists need to start looking at comparisons between our traditional

14 March 1995]PROFESSOR J A KENNERLEY, MR PETER BURLEY
DR JEAN POTTS AND DR PAM ENDERBY

[Continued

[Chairman *contd.*]

therapists with the alternative and complementary therapies that are now available to clients.

1326. In which you would include, for instance, osteopathy and chiropractic?

(Dr Potts) Yes, indeed.

1327. Which of course are now statutorily regulated under law?

(Dr Potts) Yes.

Chairman] Thank you very much indeed.

Supplementary note from the CPSM

NUMBER OF REGISTERED PRACTITIONERS FOR THE VARIOUS PROFESSIONS

Chiropodists	7,397
Dietitians	3,846
Med Lab Scientific Officers	20,930
Occupational Therapists	15,250
Orthoptists	1,109
Physiotherapists	26,097
Radiographers	17,347

15 March 1995

TUESDAY 21 MARCH 1995

Present:

Flowers, L.	Perry of Walton, L.
McFarlane of Llandaff, B.	Walton of Detchant, L.
Nathan, L.	(Chairman)

Memorandum by the Higher Education Funding Council for England (HEFCE) and the Scottish Higher Education Funding Council (SHEFC)

INTRODUCTION

1. Higher education institutions (HEIs) are the major national providers of research across all fields of science and technology, including medical and related areas. Their portfolio covers basic research into new areas of knowledge, strategic research aimed at focusing the outcomes of basic research onto particular areas of interest, and applied work aimed at a particular customer or application.

2. Funding for carrying out research and for providing research training is received by HEIs from a variety of sources, including the Research Councils (RCs), Government departments, the EC, charities, and industrial and commercial sponsors. Grant provided by the Funding Councils is usually the largest single element, but—particularly in HEIs with a substantial portfolio of research activity—it accounts for a minority of income. In the higher education sector in Great Britain, research related grant from the Funding Councils formed 38 per cent of the research specific income received by the sector in 1993–94 (the latest year for which full data are available): this proportion has been steadily falling, which reflects the fact that Funding Council grant exerts substantial leverage.

3. The HEFCs provide a block grant to institutions to support teaching and research activity. Although the Funding Councils inform institutions of the basis for the formulaic allocation, allocations within the institution are not expected to mirror the formula precisely. In particular, institutions are free to decide their own allocations among subject areas. Hence the resources provided locally for medical and related research in HEIs will depend upon the priorities of the institution. From 1994, the SHEFC has asked for, and from 1995, the HEFCE will ask for, a report on the allocation of resources in respect of research by HEIs, in order to provide greater accountability for their expenditure.

4. Funds provided by the Funding Councils are fundamental to the support of research undertaken in HEIs. By supporting the provision of premises, equipment and permanent staff they contribute to the infrastructure costs which underpin the dual support arrangements. More specifically, the research component of the HEFCs' block grant has three purposes:

- (a) It covers a majority of the costs of the basic research undertaken by universities, which forms the foundation for strategic and applied work, much of which is supported by other Government funds (from research councils and departments) and by charities, industrial and commercial organisations.
- (b) Since the 1992 change in the dual support arrangements between RCs and universities, the HEFC block grant has contributed to the costs of permanent academic staff and premises required for RC projects; it also contributes to the infrastructure costs of other collaborative research undertaken by universities in conjunction with RCs.
- (c) It contributes to the substantial fixed costs of training research students, in particular staff, premises, equipment, libraries and other essential facilities.

5. In allocating resources to institutions the Funding Councils apply a number of principles. These have been developed taking account of Government policies, and follow extensive consultation both within the HE sector and more widely. They are:

- a. **Plurality.** The Funding Councils' allocations build on the advantages which the availability of a range of funding sources brings, and seek to complement but not duplicate the aims of other funding agents.
- b. **Selectivity.** Funding Councils allocate funding selectively, according to the quality (determined through periodic Research Assessment Exercises) and (above a certain quality threshold) the volume of research carried out in each department in each institution.
- c. **Balance.** The Funding Councils seek to reinforce excellence, but also consider it important that funds should be available to encourage research potential and the development of new and interdisciplinary areas of work. Maintenance of a broad base of research and training in science and technology in the UK is essential.

*21 March 1995]**[Continued]*

- d. Competition. All HEIs are able to compete for the resources at the Funding Councils' disposal. Success, however, depends on the quality of the research undertaken and on its scale.
- e. Accountability. The Funding Councils require evidence from institutions that research activities are well managed and have clear strategic aims.

INTERACTIONS WITH THE NHS

6. To discharge their responsibilities in medical and dental education and research universities are dependent on the NHS for a range of services and facilities. The NHS is responsible for the provision of facilities to support the clinical portion of the undergraduate course and to support the clinical research carried out by the universities, the MRC and charities. Access to patients is critical for much research, where a concentration of patients with specific diseases is frequently required. The mutual interests and shared responsibility of the higher education sector and the NHS in ensuring the maintenance of high quality medical and dental education and research are enshrined in the "Ten Key Principles" which have been endorsed by the Secretaries of State for Education, for Health and for Scotland.

7. The Higher Education Funding Councils for England, Scotland and Wales are advised on matters affecting medical education and research in Great Britain by their Joint Medical Advisory Committee (JMAC). The Committee also provides advice on these issues in respect of Northern Ireland. JMAC's first term of reference specifies that it should monitor the effects of changes in the NHS on the education of doctors and dentists and on medical and dental research. The Committee has just completed a major exercise on the interactions between universities and the NHS in the provision of medical and dental education and research. Its report, submitted with the memorandum, provides the main source of evidence for the following response.

SERVICE SUPPORT FOR RESEARCH AND CULYER IMPLEMENTATION

8. The Funding Councils support the overall thrust of the Culyer Report recommendations (although it should be noted that the Culyer Report was limited to consideration of the situation in England), including the establishment of a single explicit funding stream to replace the current diverse funding mechanisms for research in the NHS. One component of a single funding stream will be the research element of the Service Increment for Teaching and Research (SIFTR) [termed Additional cost of Teaching and Research (ACTR) in Scotland]. JMAC has advised that the amount of information available about SIFTR/ACTR allocations within hospitals is relatively small and more work will need to be done if teaching and research costs are to be separately identified.

9. During the Monitoring Exercise a number of universities expressed anxieties over the potential redistribution of service support funds for research both within and between regions following implementation of the type of reform recommended by Culyer. We support JMAC's assessment that the potential destabilising effects of redistribution need not be as significant as some institutions fear. JMAC has recommended that "there is a strong case for effective modelling and piloting the post-Culyer arrangements and for ensuring that those institutions which might be net losers from a redistribution of the R component of SIFTR are protected for a limited transitional period to provide them with time to adapt to changed circumstances". As noted by JMAC, it will also be important to establish robust mechanisms for monitoring the use of NHS research funds in the new situation.

10. Another concern expressed by universities is that one of the consequences of changed arrangements for service support for research might be that a disproportionate element of funds will be diverted to pay for the NHS R&D programme. JMAC considered that "the key requirement in post-Culyer implementation will be to ensure that a balanced portfolio of clinical and health services research continues to be supported and that proper mechanisms are established for determining priorities". The Funding Councils support the principle, which guides the allocation of their own funds, that resources should be directed to work of a high quality. Culyer implementation should not lead to a situation in which service support is removed from high quality clinical research to fund other research activities.

11. The Culyer Report recommended that "a formalised assessment by research ratings like those used by the HEFCE or the 1993 review of the London Postgraduate Hospitals" be used to decide which centres should attract funding for research facilities. Clearly there are advantages to be gained if such reviews could be linked in some way to the Funding Councils' Research Assessment Exercise. Discussions have begun between the HEFCE and the NHS R&D Directorate in England to see how this might be achieved. While there is a good deal of overlap between personnel involved in medical school research and NHS directed work, the correspondence is not exact and this will need to be addressed if linkage is to dovetail into a comprehensive assessment of NHS research facilities. Also, the NHS will most likely wish to form a view on the relevance of work to health service needs. It may well, therefore, not be possible to assess NHS facilities as an integral part of the Funding Councils' assessment exercise. There are opportunities, however, for the NHS to make use of the expertise, methodology and mechanisms that have been established and the information collected in the Funding Councils' assessment exercises. Discussions are continuing in order to maximise the scope for co-operation in this way.

21 March 1995]

[Continued

12. JMAC was generally impressed by the co-operation between Regional Directors of R&D and universities. It welcomed the development of clinical and health services research programmes constructed by multi-disciplinary teams which it considered should be extended. JMAC noted that Regional Directors of R&D are likely to become even more pivotal in NHS/university research interactions following implementation of Culyer recommendations. Given this fact, it recommended that "consideration should be given to introducing an element of accountability to universities in the post of Regional Director of R&D including the involvement of universities in the appointment process".

HUMAN RESOURCES

13. A number of pressures were noted by JMAC on the time available to senior staff for research and research training. Universities have commented that increased clinical service and NHS administrative work and the reduction in junior staff hours are having significant effects on the ability of both university and NHS-employed staff to conduct research. There are also concerns regarding the potential consequences of the introduction of the unified training grade. The Funding Councils strongly support JMAC's conclusion that "there is a need for continued careful monitoring of the balance of clinical and academic work conducted by university staff if the quality of teaching and research is to be maintained".

14. Data collected as part of the JMAC Monitoring Exercise indicates considerable variation in the proportions of clinical academic staff funded by the NHS. This variation may be due to very different local circumstances or reporting practices in each of the medical schools. JMAC expressed concern that "where the proportion of support for academic posts by the NHS is extremely high (in one or two cases over 50 per cent) there are dangers of significant instability for the medical school if that funding were to become threatened".

CAPITAL PLANNING

15. The ability of universities to conduct medical research is in part dependent on the maintenance of facilities in close proximity to the treatment of patients. In recent years a number of NHS rationalisation schemes have threatened to displace existing embedded medical school accommodation. The Funding Councils have been concerned about this issue, and in 1993 the HEFCE initiated a series of meetings with the Department of Health (DH) and the Department for Education (DFE) to explore the general principles involved when embedded accommodation is displaced. Agreement was reached between the parties that:

- a. There is a critical requirement for early information on any NHS led proposal which is likely to involve the university concerned in capital funding.
- b. The costs and benefits for education and research should be incorporated and, as far as possible, separately identified within investment appraisals for NHS capital projects.
- c. As a matter of principle any costs falling upon the university should generally be proportionate to the education and research benefits which will accrue.

These principles were subsequently adopted by SHEFC and communicated to Scottish institutions.

16. In Autumn 1994 further discussions were held on embedded accommodation between representatives of the HEFCE, the DH, the DFE and the Committee of Vice-Chancellors and Principals. It was agreed that the complexity of the planning arrangements suggested the need for a step-by-step guide to the stages at which universities should become involved in NHS capital planning. Additional guidance is in the final stages of agreement with the NHS Executive and is expected to be circulated to NHS managers and vice-chancellors of universities with medical schools in England shortly. JMAC has recommended that the guidance should also be adopted in Scotland, Wales and Northern Ireland. Consideration will need to be given on how the guidance should be modified to fit arrangements in other regions of the UK.

17. During the Monitoring Exercise, one institution expressed concern that if benefits are not identified for the university and the NHS re-provides facilities, these facilities may attract capital charges. The Funding Councils endorse JMAC's view that if education and research space is currently not attracting capital charges neither should it do so in the re-provided situation. JMAC recommended that "guidance should be provided to clarify capital charging rules in relation to NHS re-provision of embedded accommodation". We understand that the NHS in England is establishing a working group to take this matter forward.

OTHER RESEARCH ISSUES

18. A number of further specific recommendations with regard to research have been made by JMAC in its Report which the Funding Councils would wish to draw to the Select Committee's attention, notably:

- ii. service support contracts should in all cases link closely the delivery of teaching and research facilities with the allocation of service support funds (paragraph 4.2).

21 March 1995]

[Continued

- ix. where high quality work of national and international significance is being conducted, whether in London or elsewhere, an appropriate volume and mix of cases should be protected (paragraph 5.10).
- xv. there should be an urgent examination of mechanisms for securing the long term service support for teaching and research in general practice settings. In the meantime the "tasked" funding should continue and its use for the purposes allocated be monitored (paragraph 8.5).
- xviii. new arrangements for the provision of service support for research should be developed on a UK-wide basis (paragraph 9.3).
- xx. the need for proper indemnity arrangements in medical research should be addressed at national level (paragraph 9.6).

March 1995

Examination of witnesses

PROFESSOR SIR MICHAEL BOND, Chairman, Funding Councils' Joint Medical Advisory Committee, PROFESSOR GRAEME DAVIES, Chief Executive, and MR DAVID NOYCE, Council Officer (Medical Education), HEFC (England), PROFESSOR JOHN SIZER, Chief Executive, and MR LAURENCE HOWELLS, Principal Funding and Policy Officer, Funding Directorate, HEFC (Scotland), were called in and examined.

Chairman

1328. Good morning, gentlemen. Thank you very much for coming. (*Professor Davies*) Thank you.

1329. You said in your memorandum that: "The potentially destabilising effects of redistribution [of SIFTR]—(I think you meant the R component)—need not be as significant as some institutions fear." No doubt you are now aware of the Winyard Report which, I understand, in the final stage of preparation, is making some proposals relating to the funding and redistribution of the T component. Do you still feel as comfortable, as that statement implies, with the future?

(*Professor Davies*) I think our comfort lies not so much with the changes, but in the way they would impact upon individual institutions over a long period of time. We have in mind, that provided the changes are managed very carefully, in a way which is quite consistent with the current Funding Council practice—to ensure that through a process of transitional funding, institutions can have determined strategies which look forward and they can fit in with that—they can then respond to the changes without doing permanent damage along the way. There is, of course, the possibility that in some circumstances, if the changes are significant, there may have to be changes in the activities of the medical schools, which are most affected, which could be perceived to have some local damaging effects.

(*Professor Sir Michael Bond*) You referred to the SIFTAG Committee which has now prepared its draft report. That will indicate that the process of moving from the present system of funding, using SIFTR, to a system in which the costs are separately identified for teaching, should take place over a period of about five years. Bearing in mind what Professor Davies has said, that should allow time for the institutions to adjust to the new changes. There is a danger, however, that the proposed formulaic approach could move too fast. What I would like to see—and I think the report will suggest it—is that the

control of the process takes place in the regional office, and that the universities are intimately involved in that process. I know the universities are likely to be denied a seat on the board of the regional office—or, at least, that was what I read in the report from this House when Baroness Cumberlege was speaking recently—but, be that as it may, I do think that the universities should, if at all possible, have a seat on the board in the regional office.

1330. In the debate on the Second Reading of the Health Authorities Bill, I did stress that crucial issue and I think you will, to some extent, be reassured by the knowledge that the Education Consortia (so-called), which will be established, will intimately involve universities in the process. I take it, then, that your wish is to see that whatever mechanism is introduced, this should take into account fully the needs of the universities and of their medical and dental and other health care schools.

(*Professor Sir Michael Bond*) Indeed.

Lord Perry of Walton

1331. The R element of SIFTR is obviously going to be looked at in relation to areas, other than those of the medical schools, for the health services besides colleges. The total money that currently goes to medical schools is both the T and the R element in total; does this mean that all money going in, in the future, will be inevitably less than they are currently getting? Do you actually believe that the medical schools are currently over-funded?

(*Professor Davies*) No.

(*Professor Sir Michael Bond*) No.

1332. So you are not worried that they are going to be even less well funded because some of this money is obviously going elsewhere?

(*Professor Davies*) I think it would be fair to say that all the Funding Councils are quite worried because this represents a squeeze from two directions. There has been a considerable squeeze coming through the funding stream, which the

21 March 1995]

PROFESSOR SIR MICHAEL BOND, PROFESSOR GRAEME DAVIES

MR DAVID NOYCE, PROFESSOR JOHN SIZER AND

MR LAURENCE HOWELLS

[Continued]

[Lord Perry of Walton *contd.*]

Funding Councils are responsible for. Then if one adds to it another squeeze from the other side, the potential for doing almost irrecoverable damage is very significant.

Chairman

1333. Let us suppose the R component is based upon the wish of Michael Peckham and his colleagues and others, who have made recommendations that the amount spent on R&D in the National Health Service should ultimately rise to the 1.5 per cent proposed. If that takes place, then there will be surely a central component of commissioned research from the Peckham department? There will also be a second component of funding for regional initiatives, which may well involve general practice and the other health care professions. It would be, no doubt, your wish to see that the facilities component remaining—the R component, to which Lord Perry referred—would be maintained, at least, at its present level? Is that what you would like to see?

(*Professor Sir Michael Bond*) Yes, that is quite correct. The split between the sum allocated to projects, on the one hand, and the facilities component, on the other, is a crucial issue. How that is to be resolved I do not know, but in the group that has been looking at the T component of SIFTR, it has been made clear that there must be common features in the facilities provided for both teaching and research, and that there will be some overlap between the two. Whatever the process is, it must involve looking at both of those elements, and ensuring that we cover both teaching and research. I think the movement of resources from the acute sector into the community in general practice is a matter that will have to be handled very carefully. In theory, of course, the transfer should be associated with the transfer of services out of the acute sector into the community and into general practice. But I have my doubts that this will be accompanied, in a parallel fashion, by the movement of research. I think they are likely to be out of phase, in which case it would be advantageous if there was some bridging mechanism to ensure that the development of research activity, within the community in general practice, did not put at risk the financial stability of the acute hospitals.

1334. Thank you. Does that imply that in addition to the streams funding teaching, on the one hand, and research, on the other, the R component must also take account of what Sir Colin Dollery has called “the sophistication factor”, meaning the fundamental support for biomedical research and basic research which may ultimately enliven patient care?

(*Professor Sir Michael Bond*) In fact, the Culyer Report indicates that all forms of research within the acute sector—and, presumably, also in general practice in the community—should be supported. I do not believe that there was ever any intention that the R component should be used only to support NHS research. In the JMAC report we make the point strongly that there should be retained a balance

between clinical research and Health Services research and we firmly believe that.

Lord Perry of Walton

1335. I was a bit bothered by the fact that in your document you say in 4(a) that the research component of your grant to each university “... covers a majority of the costs of the basic research undertaken by universities, which forms the foundation for strategic and applied work, ...” Then in paragraph 5(e) you say: “Accountability. The Funding Councils require evidence from institutions that research activities are well managed and have clear strategic aims.” Now that seems to be a contradiction.

(*Professor Davies*) I do not see it as a contradiction. What we are requiring of the institutions is that the funding which flows through the Funding Councils and is contributing to infrastructural support, is directed towards those who have greatest excellence. Within that excellence, although it is basic research, we would expect the institutions to have a strategy so that they use the money—not by spreading it around rather like jam, as a not very well directed incentive—but that they have thought very carefully about the way in which they pursue their basic research activities; how they build upon their strengths; and how those strengths are then related to the other applied collaborations. In this instance, I would include in the applied collaborations, the collaborations of the Health Service activities.

1336. I am sure you do just that, but the point is that you are using a term which has a different meaning to the rest of the world. “Strategic research” has a specific connotation nowadays.

(*Professor Davies*) It was not written in the document in that sense.

Lord Flowers

1337. Do I understand then that you would sympathise—and even encourage—universities to spend your money in such a way as to attract as much external income as possible from the NHS or wherever?

(*Professor Davies*) I would expect them to do two things. I would expect them to do that, but I would also expect them to have a very clear vision of the long term, so that they are also using our funding to bring on the young researchers; to explore areas of endeavour which are, at the present time, not attractive to the research councils or to industry. So they have to fulfil activities which may be seen to have a direct link into the clinical area; into the industrial and commercial area; but also they have to ensure that the seed core is being nurtured, so that their long-term strategic position is not threatened by short-term activities.

1338. What do you consider a prudent gearing ratio to be?

(*Professor Davies*) You will not be surprised if I say that this is a very difficult question for me to answer, because it is very much a function of individual

21 March 1995]

PROFESSOR SIR MICHAEL BOND, PROFESSOR GRAEME DAVIES
MR DAVID NOYCE, PROFESSOR JOHN SIZER AND
MR LAURENCE HOWELLS

[Continued]

[Lord Flowers *contd.*]

institutions. If I were to speculate—and it is a speculation, my Lord Chairman—my belief is that it would probably range from about 60/40, in terms of the underpinning, to 30/70, depending upon the state of an institution; whether you were bringing new people on or changing the heads of departments. Over a period of time, even within any one institution, those ratios would change progressively.

Chairman

1339. We are aware that certain universities are, in fact, deliberately top-slicing funds from the Funding Councils, in order to provide a research budget for internal distribution according to priorities. Is this something which you recommend?

(*Professor Davies*) We do indeed. This is part of having a long-term strategy—and particularly, at the moment—a good deal of that development money is aimed at bringing new young people into the system, and we would endorse that very enthusiastically.

1340. Do you believe that the transfer of infrastructure funds relating to research council grants has, in fact, resulted in that money coming back from research councils to the centres of excellence in the universities?

(*Professor Davies*) Studies of the various research councils have led us to the conclusion that with some of them the money did return to the places it went from, but this is not true of all research councils, as several members of this Committee will recall from evidence I produced on an earlier occasion.

(*Professor Sizer*) I would like to add the point that no funding model can mirror the requirements of any one institution and, therefore, all the Funding Councils recognise that we must leave it to the discretion of the institution management, to exercise their judgments as to the appropriate distribution within that institution. However, distribution of funds has to be within a framework of managing research and the institution has to demonstrate to us that there are proper internal mechanisms for accountability.

1341. May I take it that you approve of the idea that there should not be a separate research assessment exercise within the National Health Service and that, in some way, the assessment of the quality of research within the National Health Service should be wedded to your procedures?

(*Professor Davies*) I believe that it should be wedded but separate, since what has been looked for in our research assessment exercise could be different to what the Health Service is looking for. However, in the discussions we have had with Michael Peckham and colleagues, as you may know in previous evidence, we have sought to find ways in which the expertise—which has been developed in the assessment panel working on the Funding Councils' research assessment exercise—can read across to contribute, in a consistent way, to the assessments within the NHS.

1342. And mechanisms will have to be introduced, of course, to examine the quality of research in

hospitals which do not have an immediate university connection.

(*Professor Davies*) Indeed.

Lord Flowers

1343. But can you not run a joint exercise, you and Peckham, together? I am appalled at the amount of unnecessary bureaucracy these days, part of it led by you and part of it led by other people. Can you not get rid of two separate exercises and run a common one?

(*Professor Sizer*) I think, my Lord Chairman, we are well on with preparation for the next exercise, as Lord Flowers will know. The 1996 exercise has been set up following consultation with institutions, which resulted in guidance to institutions. The panel chairmen have been appointed and we are in the process of appointing the members of the panels. As Professor Davies has said, there will be full representation from within the NHS and within the medical profession on the relevant panels, but this is an exercise which is United Kingdom wide and covers all subjects and we do see some difficulties in actually taking on board something different required by one particular interest group. As Graeme has said, the English Funding Council has been having discussions with the NHS in England, and we would have thought that it would be possible to build on the work of the research assessment exercise. But we see problems in running it simultaneously.

(*Professor Davies*) I think there will probably not be a great deal of duplication, in that the activity within the clinical medical schools, which is devoted to the general development of research excellence, would be assessed in the RAE; and then in the adjunct activity those parts which were particularly devoted to National Health Service activity would be assessed, and that would require different submissions to deal with different areas of activity.

Chairman

1344. Is there not a risk, however, that separate assessment of NHS research might result in an undue concentration on relevance, as distinct from quality?

(*Professor Davies*) It must be a risk but, to some extent, that would depend on the way the panels were briefed to undertake their activity.

1345. Bearing in mind the fact that the charities and foundations produce more money for medical research than the MRC, are you taking into account the funding that comes from these sources?

(*Professor Sizer*) In the research assessment exercise, yes. All of the work funded by these groups will be submitted for assessment by the medical schools to the panels. There will be representation on the panels, as well, from the Association of Medical Charities.

Lord Nathan

1346. I wonder whether it is appropriate to ask, what is your estimate of the cost of this assessment exercise?

21 March 1995]

PROFESSOR SIR MICHAEL BOND, PROFESSOR GRAEME DAVIES
MR DAVID NOYCE, PROFESSOR JOHN SIZER AND
MR LAURENCE HOWELLS

[Continued]

[Lord Nathan *contd.*]

(*Professor Davies*) Internal costs, we believe, will be in the order of £1 million. It is not that far different from what it was last time. After the exercise was completed in 1992, we asked the institutions what they believed their running cost was, and the estimate across the sector was about £12 million. So you had an exercise which cost—give or take £13 million—but this informs the allocation subsequently, which is probably some £3 billion.

1347. Have you any knowledge as to the cost of the additional assessment in relation to the NHS?

(*Professor Davies*) No, I do not.

(*Professor Sizer*) I am not sure that is our business, Lord Nathan.

Lord Flowers

1348. How many bright young lecturers in medicine could you supply if you had that amount of money?

(*Professor Davies*) If I could make an approximate estimate, our assessment covers in the order of 70 units of activity, of which hospitalbased clinical subjects, community-based clinical subjects, clinical laboratory sciences and basic medical and dental sciences are four of the areas, and they probably represent 10 or 15 per cent of activity. If one then doubled it, for the activities which were outside the medical schools, then you are probably talking about £3 or £4 million.

Chairman

1349. Is it now likely that you are going to add on to this another assessment exercise for teaching in relation to the distribution of the T component?

(*Professor Sizer*) In Scotland we are assessing the quality of medical education in 1996/1997.

Chairman

1350. Concern has been expressed as to the potential costs of relocation of university facilities, which are embedded within NHS hospitals, arising out of urban reorganisation—not just in London but in many major centres. You touch on this, of course, in your document. Was there anything you would wish to add?

(*Professor Davies*) My first point—and I am sure Professor Bond will wish to expand on this—is the following: we are very concerned when there are not considerable levels of consultation between the health authority, which may be driving the move, and the institution, which may have to respond to it. As is made clear in the memorandum and the JMAC Report, there have been some dangerously worrying experiences in the past, where one was driving the other without due consideration. To that end we sought—as you again will recall if you look at paragraph 15 of our memorandum—to agree protocols with the Health Service, to seek to minimise the damage that might be done. The life of those protocols has not been quite as easy or smooth as one might have wished.

1351. Going back almost 20 years, when I was Dean of the medical school in Newcastle, we planned a new medical school and a ward block with several NHS departments in the medical school, and several university departments in the ward block, and the costs were shared between the UGC and the Health Service. However, one of the problems was that the NHS measured to the inside of the party walls and the UGC measured to the middle of the party walls, so planning went rather awry. Does that problem still arise?

(*Professor Davies*) I suspect, in a logistical way, it probably does.

1352. Because we found ourselves 1.5 per cent over area at one stage.

(*Professor Sir Michael Bond*) The main difficulty we have, my Lord Chairman, is that first, as Professor Davies has said, universities are not always brought into the picture as soon as they should be. It was a feature of the agreement reached in 1993 that this should be taken on board. Secondly, it is quite clear that the nature of provision for clinical medicine in the future, on the one hand, and the way in which medicine will be taught, on the other, will not be the same as in the past. It is very difficult for universities to demonstrate whether there is, or is not, added gain to them in a new arrangement. That is an important matter because, at the moment, we are on the threshold of an understanding that it will only be in the case of added academic gain that universities will have to find a proportion of the costs. As yet, we do not have a method for determining added gain. Now, hopefully, the guidelines referred to in our memorandum will be forthcoming in the near future and will give a lead in this direction. It would certainly be appreciated if that could be moved along.

1353. So joint planning is the order of the day and that is something upon which you would wish to concentrate?

(*Professor Sir Michael Bond*) It is essential. There is one other point I would like to raise, my Lord Chairman. In my own area, the Western Infirmary in Glasgow is likely to be relocated on a new site and private funding may well be used in that exercise. But if universities demonstrate added gain in such a situation and have to pick up some of the costs of a private funding initiative, that could incur them in a good deal of expense which they may not be able to meet. As it is, they have a good proportion of their money set against students' residencies, for example, where there are private funding initiatives, but I think the system would have great difficulty in supporting the additional costs of a sizable proportion of private funding for new hospitals.

Baroness McFarlane of Llandaff

1354. Although the proportion is variable, some medical schools are now heavily dependent on clinical academic posts funded by the NHS. We wondered whether you considered this development had gone too far, or should it be extended?

(*Professor Sir Michael Bond*) I am sure you are aware that there is a history to this development. Looking at the figures, it is quite interesting to see

21 March 1995]

PROFESSOR SIR MICHAEL BOND, PROFESSOR GRAEME DAVIES
MR DAVID NOYCE, PROFESSOR JOHN SIZER AND
MR LAURENCE HOWELLS

[Continued]

[Baroness McFarlane of Llandaff *contd.*]

that where there are more than 40 per cent of NHS funded clinical academic staff, you find them in what I would regard as the newer medical schools. Indeed, one of the ways in which they gained strength academically was, in fact, with help from the NHS. That was the first thing that happened. The second was that the NHS itself sought to strengthen its own resources and put money into areas where it had an interest—psychiatry was one which comes to my mind. Then, in the 1980s, as you will know, there was a significant cut-back in universities funding, and at that point the NHS resources were used to fund additional academic posts. For example, in Scotland, 30 additional posts were added to the system at that time. More recently, because of the considerable financial constraints placed upon medical schools, they have sought support again from the NHS for academic posts. So really, from the 1960s onwards, universities have had to look to the NHS to help them. (The older universities have been protected to some extent, I suspect, by virtue of the fact that they have very significant endowments to support their posts.) But there are dangers in this situation. We made that comment to schools that have very high levels of NHS funded staff. The highest we noted was in the region of 57 per cent at Nottingham. The danger is that the Health Service may choose to discontinue working in an area or it may not wish to refund a post when it becomes vacant. I have come across examples of where that has happened, and there was considerable difficulty in finding the funding for a post which the trust did not wish to continue. However, I think it would be fair to say that our study showed that there was a slight net gain in academic posts over the 3-year period in which we were interested. Therefore, there is no evidence, at the moment, of a flight of resources from NHS funded clinical academic posts.

Chairman

1355. Do you commend the development of academic posts in medical clinical disciplines in so-called postgraduate schools, established in universities without undergraduate medical schools?

(*Professor Sir Michael Bond*) The fact of the matter is we cannot stop it happening.

Lord Perry of Walton

1356. Even in the old medical schools: I went to see the Dean in Edinburgh and I discovered, to my surprise, that there are 67 senior lecturers—not honoraries but senior lecturers—in the university list. When I asked for an explanation I was told they have a contract with the university for two sessions of work in teaching and research, but they are entirely paid by the NHS. That would be, would it, that they would take a fifth of that number? In other words, they would take a full-time equivalent in contracting it?

(*Professor Sir Michael Bond*) All clinical academics have a mixed contract. We are all contracted to six sessions of NHS work and we are left with four sessions, out of a ten session week, for our academic work. The arrangements that have

been made are, by and large, relaxed. That is that departments contract with their trusts for the total supply of services. This allows for individual academics to move about reasonably freely, but it ensures that NHS contractual arrangements are met.

Chairman

1357. These are people paid by the National Health Service, but they have within their contracts a requirement to work two sessions for the university in Edinburgh. Other universities have done it in a different way, by carving up academic posts and making A+B appointments, joint NHS and university.

(*Professor Sir Michael Bond*) There is a variety of options, in terms of the sessional basis, of such posts. In Scotland we do not have A+B posts. They do not exist. Nor do we have, as far as I am aware, sessional arrangements of the type you describe, other than in Edinburgh.

Lord Perry of Walton

1358. If they are only doing two sessions with the university, the pressure will be on them to do more and more clinical work and this is likely to interfere with that small amount.

(*Professor Sir Michael Bond*) Yes. The fact of the matter is that the pressure to do clinical work is very high for all academics. Of course, they will be at even greater risk, but one of the factors that now puts people off joining the academic world is the fact that there is a considerable burden to be borne, in terms of clinical practice and in administration linked to NHS activities.

Baroness McFarlane of Llandaff

1359. You say that there are dangers in extending this; but there are also advantages. Have you a view as to what the present situation is? Is it about right in proportion?

(*Professor Sir Michael Bond*) It varies so much from place to place. It varies from zero to 57 per cent. There is no average. I suppose the bulk of medical schools have somewhere between 20 and 40 per cent of their staff funded by the NHS. That does seem to be reasonably comfortable. We did not gain any evidence in our recent exercise that those figures were under threat. Indeed, there seemed to be a slight increase. There is a situation ahead of us, however, that may require us to look at this again. That is, looking at the consequences of the Calman Report where, with shortened training periods and an increase in consultant numbers, we will come up against the question of the proportionality between clinical academics and NHS consultants, which would be severely imbalanced unless there is some further increase in the number of clinical academics. But I cannot see that happening without some help from the NHS, because I do not believe the universities could cope with that problem on their own.

21 March 1995]

PROFESSOR SIR MICHAEL BOND, PROFESSOR GRAEME DAVIES
MR DAVID NOYCE, PROFESSOR JOHN SIZER AND
MR LAURENCE HOWELLS

[Continued]

Chairman

1360. And, of course, we are faced with the problem that may arise from the reorganisation of the English regions; with the disappearance of the regional health authorities and the question as to whether the new regional offices will be in a position to fund these new academic posts, or whether they will all in future have to be funded by trusts. As you have raised Calman, what is your view on the possibility of individuals entering the new registrar training grades being able to take time out? Will they hold their training number, while moving out into research posts, before coming back into the formal training programme?

(*Professor Sir Michael Bond*) I think it is vital that happens. I am not aware that the Calman Working Party, which is looking at the consequences for academic medicine, has reported—or if it has, it has not reached me. Those of us in clinical academic medicine would strongly support the view you have just expressed; that training numbers should be available—reasonably and liberally—to people who wish to take an academic career, to allow them to move out and back, as and when it is necessary for them to do so.

1361. We are told that should they go out for three years, say, the vacancy then created can only be filled by a visiting registrar. Is that practicable, or is it not likely to be necessary to have a quota of such numbers, in order that these vacancies can be filled when the original trainee moves aside?

(*Professor Sir Michael Bond*) The quota arrangements may be necessary in order to maintain some order in the system.

Baroness McFarlane of Llandaff

1362. Is there a concern that the expansion of the NHS consultant numbers, without a concomitant expansion of clinical academic posts, will diminish the influence of academic medicine in teaching hospitals?

(*Professor Sir Michael Bond*) The answer to that is yes. The academic community is necessary to the NHS. It should be there to provide academic leadership and training. If there is an imbalance we could find that the ability of clinical academic staff, in terms of controlling the processes that I have just mentioned, would be weakened quite considerably. That would be a mistake.

Chairman

1363. Do you wish to say anything about the running sore of the annual pay awards for NHS consultants and clinical academics?

(*Professor Davies*) I think we would prefer not to.

1364. I thought you would!

(*Professor Davies*) Other than to make the point that the Funding Councils have always, since their foundation four years ago, taken the view that matters concerning conditions of employment are for the employers, which are the institutions.

Lord Perry of Walton

1365. You said earlier that you would not be able to envisage a comparable increase in senior lecturer posts in the universities from university funds, which means that if there is to be an increase—a concomitant increase in academic consultants, as it were—these would have to be funded by the NHS. But, if that is so, then it means, of course, that the control of a great deal of teaching of medicine moves out of the hands of the Department of Education to the Department of Health. Do you not think this is a fairly serious thing to contemplate?

(*Professor Davies*) We believe that to maintain the balance is really quite critical. If it swung in one direction, so that one of the departments became dominant, my personal belief is that this would not be in the interests of the medical schools.

(*Professor Sir Michael Bond*) That is correct. I think one has to say that once the NHS has funded a post, in my experience it tends not to interfere. That is the essential fact. If, however, interference did begin, then I think the whole system would fall apart. But, to date, that has not happened.

1366. If it was public money coming from the same purse, why should it not be done through the university system, by increasing the number of senior lecturers?

(*Professor Sizer*) Could I comment on that context? We are currently faced with an indicative funding scenario of 3 per cent efficiency gains per annum, in real terms, over the next three years. The only way we could put more money into medicine, at the moment, is by significantly moving money out of the disciplines. Now, if there was a transfer of resources from the National Health Service to the Funding Councils we could deliver, but other than that we would have to leave it to individual vice-chancellors to decide whether, within their reducing pot of gold, they wished to reallocate some of their resources towards medicine; but I do not think we could do it unless we got specific directions from the Secretary of State.

Chairman

1367. As the old saw had it, the definition of hell was a vice-chancellor with two medical schools!

(*Professor Sizer*) That is right.

1368. The received view 25 years ago was that it was illegal to pass money across the boundary between the Department of Health, on the one hand, and the Department of Education, as it then was, on the other. But, in fact, now for many years, this money has been handed directly, has it not, to the universities by the NHS; and these people, who are funded through the NHS, are nevertheless the employees of the universities? Is that the case?

(*Professor Davies*) I think, in the majority of cases, this is so.

(*Professor Sir Michael Bond*) What we do is recoup annually the costs of the staff who are being funded by the NHS; and, of course, there is a counter-stream of people who are funded by the universities, who work in the NHS, so there is a counter-recoup.

1369. Long may this partnership continue.

(*Professor Sir Michael Bond*) Indeed.

21 March 1995]

PROFESSOR SIR MICHAEL BOND, PROFESSOR GRAEME DAVIES
MR DAVID NOYCE, PROFESSOR JOHN SIZER AND
MR LAURENCE HOWELLS

[Continued]

[Chairman *contd.*]

1370. Are you having difficulty in filling posts? Are the universities having difficulty in filling appointments of deans of medicine?

(*Professor Davies*) I think that along with most senior administrative posts advertised, there are difficulties, since, as Lord Flowers commented earlier, the administrative demands and bureaucratic demands which come from Funding Councils (but not solely from Funding councils) have made life much more difficult.

1371. Sir Michael, would you wish to comment upon the Kendell proposal; that if someone does leave a clinical appointment whole-time in an academic discipline to become a dean, that some means should be found of preserving their rights to a distinction award?

(*Professor Sir Michael Bond*) Yes I do, my Lord Chairman. I have had extensive correspondence with the body in Scotland responsible for meritorious awards about this very issue, because I felt very uncomfortable myself. Being an administrative dean of a faculty of medicine, which inevitably means my contribution to clinical life is less than it was before I became the dean, I was reassured that service to the NHS does not simply mean clinical service to the NHS, it has a much broader basis than that. I was reassured by that comment. If I could make a comment about the deans' work: it is no longer an afternoon job. There is no doubt about that.

1372. I do not think it was some time ago!

(*Professor Sir Michael Bond*) There are twin pressures exerted on deans. Within the university

system we have the research assessment exercise; the quality assessment of teaching exercise; devolved budgets; the new curriculum; all of those. On the NHS side we have trusts; we have the imminent issue of splitting SIFTR into R and T. In fact, things have not been stationary. In many places sub-deans have been appointed to take care of different areas of work and the medical schools have employed external agencies to carry out a certain amount of work for them. On the NHS side, quite a number of schools now have what is called a SIFT monitor—a person who is employed on SIFT money—to look at the contracting process primarily. My view is that with the arrangements that are likely to be set in train very shortly for T and R, the deans' offices will have to be strengthened further. They will need a contracts manager, there is no doubt about that. They will need somebody who is not only able to set the contract but also to monitor it, and that person will need supporting staff. Again, I take the view that the funding for that should come from the Health Service side, and I say that because it is really Health Service money that is being dealt with. SIFT cannot be handed over to the medical schools, but the medical schools will be responsible for setting the agenda for its use, in collaboration with purchasers and providers. However, I do believe that as a lot of activity will take place in the deans' office and in the regional office, the deans' offices must be strengthened in the future still further.

Chairman] Thank you, gentlemen, very much.

Letter from the Chief Executive of the Higher Education Funding Council for England

MEDICAL RESEARCH AND THE NHS REFORMS

At the close of our meeting last week with Sub-Committee I, Lord Walton of Detchant suggested that we might like to write stating our views on the Steering Group on Undergraduate Medical and Dental Education and Research (SGUMDER) and whether it could be made more effective as a means of bringing the health and education interests together.

May I first say how much we value the existence of SGUMDER which has played a pivotal role in ensuring over the last few years that the interests of medical and dental education and research are not forgotten at a time of considerable change in the health service. In particular the "Ten Key Principles", which the Steering Group enunciated in 1990 to define better the shared goals of universities and the NHS, have provided an invaluable point of reference for guiding both local and national actions. Our Joint Medical Advisory Committee (JMAC) as part of its recent monitoring exercise was asked by the Chairman of SGUMDER to assess the extent to which the "Ten Key Principles" were being adhered to and were still relevant to the changing pattern of University/NHS interactions. It noted that, "at the time of their development the Steering Group did not include in its terms of reference research and consequently the principles did not generally refer to this aspect of joint working". JMAC accordingly recommended that, "SGUMDER should rewrite the Ten Key Principles to ensure their wording fully reflects the current situation".

JMAC's Report identified a number of areas requiring attention if the quality of medical and dental education and research is to be maintained and enhanced. Among issues highlighted by JMAC which we believe could fruitfully be examined by SGUMDER are:

- (a) academic consequences of the movement of resources from the acute sector to primary and community care.
- (b) monitoring of the balance of clinical and academic work conducted by university staff in the light of the junior doctors' hours initiative and implementation of the Calman training proposals.
- (c) post-Culyer effects on academic research.

21 March 1995]

[Continued

The Steering Group plays an essential role in bringing together a wide number of interests including the NHS, the HEFCE, the Committee of Vice-Chancellors and Principals, the General Medical Council, the General Dental Council, the Medical Research Council, the Association of Medical Research Charities and others. Given that so many different parties are represented there is a danger that discussion may be of such generality that issues cannot be readily concluded. SGUMDER has in the past been most effective when it has empowered working groups to investigate particular areas of concern. Examples of substantive consequences resulting from this approach have included the tasking of Regional Health Authorities to provide service support for academic general practice and the allocation of Medical SIFTR funding for the teaching of human disease to dental students. We would support extending this method of working with terms of reference for working groups being set by the main Steering Group and detailed recommendations being referred back for wider agreement.

I hope that these comments are of use to your Committee in preparing its Report.

29 March 1995

Memorandum by the British Medical Association

1. INTRODUCTION

1.1 The NHS is in the business of preventing illness, promoting health and providing health care. Like any business, Research and Development (R&D) is essential to improving the product, namely the service offered to patients, carers and the public.

1.2 Robin Downie, Professor of Moral Philosophy at the University of Glasgow, who has made a study of professionalism in many fields, has identified six key attributes of the professional. These include a commitment to maintain and improve the standard of service provided through involvement in, and support for, professional bodies. The British Medical Association (BMA), representing through its membership around 80 per cent of doctors practising in the UK, therefore has a deep commitment to improving quality of health and health care through a robust NHS R&D strategy.

1.3 We welcome the opportunity to give evidence to this Committee. It is essential that the NHS should have an R&D strategy, which not only maintains Britain's fine tradition of world-class medical research, but also focuses on constant improvement in the quality of care given to the individual NHS patient. Most of all, such a strategy must allow for, and engage, the enthusiasm of the ordinary doctor in undertaking curiosity-driven research in their everyday field of work.

1.4 The November 1994 Conference on "Core Values for the Medical Profession in the 21st Century" identified "a spirit of enquiry" as one of the most enduring qualities of the doctor. That spirit of enquiry should be harnessed and fostered by any NHS R&D strategy for the benefit of individual patients and the British public as a whole.

Q1. *What is your assessment of the NHS R&D Strategy? You may wish to comment on the centrally-commissioned programme, the role of the Regional Research Committees and Regional Directors of R&D, health technology assessment, the Cochrane and York Centres, the Research Liaison Committees or any other aspect of the Strategy. Do you have advice for the NHS Director of R&D as he takes the Strategy forward?*

2. BACKGROUND

2.1 The British Medical Association (BMA) has fully supported the NHS R&D Strategy, viewing it as a long overdue initiative for co-ordinating and stimulating research within the NHS. The BMA's Board of Science and Education, responded to *Research for Health*, published in 1991, that outlined the proposal for an R&D Strategy, and additionally provided more detailed comments on the report on progress with the Strategy, published in 1993. Key issues raised in the Board's submissions were: the need for adequate education of medical students in research; the development of a research culture within the NHS that infiltrates to all health professionals; the funding of basic research in a highly directed research programme; the development of scientifically and ethically based treatment protocols/guidelines and the dissemination of research findings in order that doctors may make the best use of available resources for their patients. (The Board's submissions are attached as Appendices one and two to this submission).

2.2 Additionally, the Board and BMA as a whole, have responded to consultations on priorities in specific NHS R&D areas, for example, asthma, methods of implementation, health service delivery issues, health technology assessment, dental care and nutrition. The BMA has welcomed the opportunity of contributing to the identification of national research priorities and has emphasised the need for broad consultations that take into account the views of patient groups as well as those of researchers and the health professions.

21 March 1995]

[Continued

3. THE ROLE OF THE NHS R&D STRATEGY

3.1 The NHS R&D Strategy has provided a focus for non basic research within the NHS, a framework for the management and implementation of NHS research, and a structure for identifying research needs. The Central Research and Development Committee (CRDC) has a key role in ensuring that all those that play a part in NHS R&D are represented at a strategic level. However, the large size of the committee, necessitated by the need to ensure appropriate representation, means that its role can only be advisory.

4. DISSEMINATION OF RESEARCH FINDINGS

4.1 The dissemination of research findings is key to the success of the R&D Strategy. There has been much criticism that the UK's research and health care systems do not facilitate the transfer of research findings into purchasing strategies and to clinical practice. With regard to purchasing, these deficiencies have been compounded by the move towards smaller purchasing units ie total fundholding. Where a large, structured, organisation such as a health authority, is responsible for purchasing care, there is greater facility for dissemination of information throughout the structure to inform purchasing decisions. Ensuring such knowledge is available to far smaller purchasing units needs greater consideration. The Director of Public Health has a key role in providing medical advice for purchasing decisions and should be responsible for ensuring that the results of research influence purchasing decisions. Additional mechanisms may be needed, however, to ensure that GPs purchasing strategies are consistent with effectiveness.

4.2 Criterion-based clinical audit will facilitate movement of research findings into clinical practice and audit methodology, and therefore needs incorporation into medical education.

4.3 Information management within the NHS should be linked with the R&D Strategy. Information technology has become increasingly important within the NHS and will continue to be in the future. Information management systems should be employed to facilitate dissemination of research findings and to co-ordinate the R&D Strategy across regions, hospitals and trusts. With continued difficulties over NHS staff being granted study leave, information technology accessible throughout a large organisation can offer all practitioners a highly-polished decision support mechanism.

4.4 The NHS R&D Strategy has established a number of mechanisms to enable research findings to influence clinical practice. The Cochrane and York Centres have a vital role to play and the BMA fully supports these initiatives. However, there is a responsibility attendant on all individuals involved in medical research to promote awareness of the results of their work in the medical profession and the public. This will improve the public's understanding of the development of medical knowledge and of effective treatment options, and assist decision making on clinical management between doctor and patient.

4.5 The need for evidence-based medicine has received a great deal of attention both in the medical literature and within the national media in recent months. The forthcoming NHS R&D programme and BMJ conference on this subject that will coincide with the launch of a new BMJ journal on evidence-based medicine, will lead to further progress in this area.

4.6 It should, however, be borne in mind that it is not possible nor desirable in some cases to obtain evidence for every treatment option before it is utilised in patient care. Striving towards evidence-based medicine should not prevent the use of treatments where evidence is more equivocal.

Q2 What is your response to the Culyer report on "Supporting Research and Development in the NHS" (HMSO, September 1994)? Do you have suggestions, or concerns, as to how it might be implemented? You may wish to comment on service support for curiosity-driven research in NHS hospitals; tertiary referrals in the internal market; the consequences for clinical trials; or any other issues raised by the report.

5. IMPLEMENTATION OF THE CULYER REPORT

5.1 It is of note that the Secretary of State for Health has already announced that a new system for funding R&D in the NHS is to be introduced in the light of the Culyer Report. The new system of funding will be introduced in 1996-97 and relates to the following specific recommendations of Culyer:

- The introduction of a single funding stream for NHS R&D, service support for R&D, and research facilities.
- Raising R&D funds through a levy on purchasers of health care.
- Changes in the advisory structure for R&D including revised terms of reference and membership for the Central NHS R&D committee who will have a new role in advising the NHS on how to invest its R&D funds.
- The creation of a national forum to bring together the major health-related research funders to provide advice for the NHS and the Government.

21 March 1995]

[Continued

6. SINGLE FUNDING STREAM

6.1 The BMA welcomes the key recommendation of the Culyer report to introduce a levy on all purchasers to fund R&D. Although theoretically this funding system differs little from "top slicing" the levy will ensure that all purchasers have "ownership" of R&D and realise the importance to improved patient care and efficiency. As yet the size of the levy has not been determined and will need careful calculation, in particular to take into account the additional costs of the introduction of a new system of funding. The levy should be continually monitored and increased in the future if the effectiveness of this approach in improving patient care and hospital efficiency is realised. This levy should counter the problems that have arisen for research due to the effects of the internal market that is now an integral feature of the NHS.

6.2 The enquiry has specifically requested views on the position of tertiary referrals in the internal market. Currently a health authority can refuse to fund an extra contractual referral from a general practitioner. However, health authorities are obliged to fund tertiary referrals. These referrals are often crucial to establishing an adequate patient base for highly specialised research and any obligation to fund them should therefore be maintained.

7. BASIC RESEARCH

7.1 One of the values that guided the work of the task force producing the Culyer report, was that NHS funded R&D should follow explicit priorities (Appendix A—Values guiding the work of the task force). Within the Culyer Report (para 3.39) it is stated that the research funds originating from the levy on purchasers will not cover the costs of R&D in NHS providers for pre-protocol and curiosity-driven exploration. The value of such work is recognised, however, and it is recommended that purchasers of health care allow providers the freedom to continue to support pre-protocol work, curiosity driven research and similar activities, and to provide for the costs where these cannot be met by external sponsors.

7.2 Although it would seem appropriate for NHS R&D funds to be directed into non-basic research and for other organisations, such as the MRC, to focus on basic research, it needs to be considered whether the highly co-ordinated and directed approach proposed in Culyer could have a detrimental effect on externally funded basic research. The Culyer report recommends recasting of the Central Research and Development Committee to provide advice on all issues relating to R&D which have implications for NHS funding. This extended role will see the CRDC not only advising on research priorities for research funded directly by the NHS but also upon the advisability of the NHS providing service support to R&D funded externally. There is a danger that the CRDC may not view the provision of funds for service support for basic research as consistent with their directed programme. *The value of long term, fundamental clinical research must be realised by the CRDC if we are not to lose very important areas of research that require service support from the NHS.*

7.3 The benefits of local research, in particular its role in encouraging inspirational/curiosity driven research, needs to be recognised. Given their independence, it is important that trusts individually should be supportive of the NHS R&D programme and be required to participate in NHS R&D.

8. NATIONAL FORUM

8.1 The creation of a national forum, to exchange information about the research strategies of the national bodies which sponsor or support R&D in the NHS is to be welcomed, in order to prevent duplication of effort and to ensure that research priorities of different funding bodies complement one another. Care is needed to ensure that the forum does lead to truly complementary programmes as there is a danger that it could lead to too great a level of co-ordination of research programmes of such organisations. *There is a need for a plurality of sources of funding for research and a plurality of views on priorities.* Organisations that fund medical research should therefore retain their independence in terms of setting R&D priorities.

9. RESEARCH FACILITIES

9.1 The report discusses the funding needed to maintain a research infrastructure and this is primarily through the teaching hospitals and institutes. Financial support for such bodies will be dependent upon their performance and it is suggested that assessment could be based on that currently carried out by the Higher Education Funding Council. Although funding should flow to centres of excellence, such a system of determining funding may impede development and improvement of research centres as those who are attempting to make such improvements may find it difficult to obtain the funding to do so.

9.2 A second area of concern is that funds are no longer available from Regional Health Authorities (RHAs) for the establishment of academic units. In the past RHAs have often provided funds for Universities to establish clinical academic units in specialities where academic development is needed; geriatrics, for example.

21 March 1995][Continued

9.3 Although the report discusses the need to maintain a research infrastructure there is no mention of the clear relationship of cross support between the NHS and university sector, which it is important to maintain. The research role of university staff must be retained as a vital part of this research infrastructure.

10. THE COMPLEMENTARY ROLES OF EDUCATION AND RESEARCH

10.1 All centres of higher education should also undertake research. The idea that higher education centres could be "teaching only" is not acceptable. An environment in which research is being carried out is essential to a rounded education particularly in relation to medicine. The practice of medicine uses similar reasoning to that of research and therefore medical students should be educated in a research environment. All institutes of higher education need funding to maintain or establish a research infrastructure; centres of excellence could command additional funding.

11. PRIMARY AND COMMUNITY CARE

11.1 The recommendations regarding the funding of research and development in primary and community care are welcome, although there are few details as to how the development of a research infrastructure will be achieved. In addition, the difficulties for independent contractors undertaking research has not been addressed. No mention is made of the possibility of establishing designated research general practices or academic practices as proposed by the Royal College of General Practitioners. The changing nature of the health service with individuals increasingly being cared for and treated in the community necessitates a change in medical education. The GMC has recommended that medical students should gain more experience in general practice and in community health services. However, currently there are no funds available to general practice/community medicine to cover the service costs of teaching. If funds are to be made available to general practice and community care for research there is an urgent need to consider providing access to funds for teaching.

12. DISSEMINATION OF RESEARCH RESULTS

12.1 Within the NHS R & D Strategy great emphasis is placed on the need for dissemination of research results in order that purchasers and health professionals may receive the information they require on different treatment options. An aim of the Strategy is to ensure faster introduction into the service of effective methods and discontinuation of unwanted interventions. It is therefore, somewhat surprising that the Culyer report makes no recommendations regarding this important part of the overall Strategy. Under Culyer's definition R & D ends at the point at which generalisable results are published. The report states that it is outside its remit to deal in detail with the implementation of R & D results in particular settings. However, a cornerstone of the NHS R & D Strategy is the introduction of mechanisms to facilitate a move towards the practice of evidence based medicine and the Cochrane and York Centres are most welcome in this respect. Obviously, service development is firmly within the province of innovative health care purchasing and provision, but the concerns that led to the production of the Culyer report re the conflict between the internal market and research, may also apply to implementation of research findings where these can lead to more costly but effective services. *The BMA would therefore urge the further review of the funding arrangements for the introduction of evidence based medicine as outlined in para 3.118 of the Culyer report.*

Q3. *Do you identify additional challenges or opportunities for UK medical research which neither the NHS Strategy nor the Culyer report addresses?*

13. PAY FOR RESEARCH

13.1 The quality of research in the NHS will depend largely on the quality of doctors and other researchers undertaking that research. The financial reward and career structure for such research needs to be at competitive levels to attract the best individuals. The relatively low pay for research and lack of a clear career structure is an issue that has not been addressed by the Culyer report.

14. JUNIOR DOCTORS AND RESEARCH

14.1 One area of particular concern to the medical profession is that of the education of junior doctors, particularly whilst they are studying for a higher degree. The arrangements for, and management of, juniors undertaking research leaves a lot to be desired. Unless the doctor is associated with a university department (and in some cases even when they are) they may find themselves undertaking unsupervised research for an MD. Junior doctors' research needs to be managed and supervised with appropriate funding.

14.2 With the abolition of regional health authorities the problems of adequate supervision of junior doctors are likely to increase. Juniors' on contracts should not be held by trusts as this would result in too much emphasis on the service element of the contract. If the contract was held by the Postgraduate Dean,

21 March 1995]

[Continued

perhaps jointly with the trust then time for research could be protected. *The Postgraduate Dean, University, and Regional Director of R & D should together work out a system of supervision and funding of research carried out by junior doctors.* Doctors undertaking supervised research are more likely to be successful in their endeavours. If juniors' research formed part of the overall regional R & D Strategy then any worthwhile findings could be disseminated through the R & D system.

14.3 There are particular concerns relating to the new unified training grade. The BMA is concerned that those doctors appointed to the "Specialist Registrar Grade" will come under significant pressure not to step outside the grade in order to pursue academic, including research, interests. The Department of Health has been asked for clear guidance on how participants in the grade can advance within it whilst maintaining an academic interest.

March 1995

Examination of witnesses

DR A W MACARA, Chairman, PROFESSOR J B L HOWELL, Chairman, Board of Science and Education, DR P DANGERFIELD, Deputy Chairman, Medical Academic Staff Committee, Member, Board of Science and Education, and DR E M ARMSTRONG, SECRETARY, BRITISH MEDICAL ASSOCIATION, were called in and examined.

Chairman

1373. First of all, we would like to express our sincere thanks to you for your very helpful and detailed submission, which the Committee have read with great interest.

(Dr Macara) Thank you very much, my Lord Chairman. First of all, we perceive a danger that whilst we very much applaud the proposed Central Research and Development Committee, and very much applaud focusing upon national priorities of problem-based research, we do see a danger that this could cloud the awareness of a need to provide service support for what Culyer describes as "curiosity-driven, basic non-directed research". Also, whilst very much applauding the national priority and problem-based research direction, we are anxious that this will not make it more difficult for people to pursue curiosity-driven research. Secondly, we are concerned, lest the proposed system for determining the funding of research centres of excellence could impede the development of new centres. We would see a danger that centres which are trying to make improvements, starting from a low basis and badly needing to develop, might find it difficult to obtain funds, as the money will flow to those centres which have already a good track record, and which have already demonstrated excellence. To them that have, shall be given; from them that have not, shall be taken. That is very much the university selectivity problem. Then there is the matter of the importance of tertiary referrals for specialised research needs. We would support an emphasis upon the importance of these referrals. We would observe that although consultants are free to make such referrals there are elements in the current internal market system which might inhibit them from making such referrals. We feel that specialised research work undertaken in centres of excellence is reliant on tertiary referrals and therefore it is important that should be protected. There was also a hope (perhaps not entirely or immediately within your remit) that the successors to the regional services advisory group might need to find some means of supporting the tertiary centres so that they are competitive in attracting funds. We are

concerned to avoid any suggestion that there should be any centres of higher education which are teaching only. We feel all centres of higher education should undertake research and that students in medicine, whether undergraduate or postgraduate students, do require education and continuing education within a research environment if we are to cultivate a culture of enquiry and of personal development. With the shift in medical care from hospitals and institutions to the community and primary care a shift in medical education is following assisted, of course, by the General Medical Council's revised recommendations, and we feel that funds will need to be made available, therefore, for teaching and research in the community specifically in primary care. Switching to look at junior doctors; we note there is currently no clear system for protecting time for all junior hospital doctors to undertake education and research, although we are aware of the fact that senior registrars currently may do so. We feel that the juniors' contracts should be worked out between the postgraduate dean, university and the regional director of research and development to ensure that a system of supervision, and the funding of research carried out by junior doctors, can be developed. We are, of course, in very urgent discussion with the Department of Health about that in relation to the current Health Services Bill. There continue to be, and we are all aware of this, unacceptable delays in applying NHS pay awards to medical academic staff. The importance of this among other factors is that it does lead to poor morale among clinical academics. In conjunction with other factors, such as the difficulties of finding time to undertake research, following an academic career, has sadly become a much less attractive option especially for bright young doctors. These various points, in our submission, make it clear that there are many barriers to doctors undertaking research and to entering medical academic careers. The BMA would therefore welcome your suggestion that there might be a need for a thorough review of medical academic careers following logically on from the Culyer report.

1374. We have had a good deal of evidence about the problems relating to extra-contractual and

21 March 1995]

DR A W MACARA, PROFESSOR J B L HOWELL
DR P DANGERFIELD AND DR E M ARMSTRONG

[Continued]

[Chairman *contd.*]

tertiary referrals for research purposes. One suggestion that has been made is the possibility that certain funds might be retained at a regional or even national level to which application could be made to protect such tertiary referrals. Is this something which if properly managed might be an attractive idea to you?

(*Dr Macara*) It sounds imaginative. I imagine that Professor Howell, who wears a specific hat as chairman of a health authority, might have some observations to make.

(*Professor Howell*) The whole question of protecting referrals to the centres of excellence to improve the quality throughout care is one that is under threat. It is under threat because the costs of these units are higher than equivalent caring units who are not doing the special treatments. I think one solution which I would support would be if this came under the orbit of the Super Regional Services Advisory Group because it would seem to me that a supplement to these centres of excellence to bring their service costs back to those of the NHS as a whole would solve this problem. I think it is a problem. Although consultants may refer tertiary referrals without inhibition, the health authorities may not stop this; it is only from general practitioners that they have control. I think there is a pressure on consultants in the general environment to try to keep down costs for their own trust and, therefore, I think they are inhibited from making freer referrals. If the costs were the same then this would be removed.

1375. That is a very helpful suggestion. It would not, however, overcome one problem that has been brought to our attention and that is that even if the costs are levelled out, certain consultants in peripheral regional hospitals and managers are nevertheless reluctant to refer patients where they say they can perfectly well be treated in their own hospitals. That is not an easy problem, is it?

(*Professor Howell*) No, that is a very real problem for which I think a different solution is needed. We know that in the management of many malignancies the results in some places are very very significantly lower.

1376. Please say more about the Calman proposals relating to the unified training grade. There is a proposal for there to be a special quota of National Training Numbers for recipients of MRC Clinician Scientist Fellowships and equivalent awards and for them to step aside for up to three years while retaining that number to come back into training. Is this something that you in the BMA would commend? The reason I say this, without being pejorative, is that it has been suggested to us that in the past the Association has sometimes not been attracted by this idea because they have felt that those on the academic training ladder compete, perhaps not always on equal terms, with those who are coming up the standard training ladder seeking consultant posts. What is your view?

(*Dr Macara*) We have a clear view from our junior doctors which we endorse, and I think by way of background to this, one should indicate that we expect the report of the academic and research sub-group of the Unified Grade Working Party to be published for consultation in the near future. That

will give us an opportunity to pursue this matter. We would particularly welcome the opportunity to present additional evidence once the details of that report are known, but our current view is that the proposed curricula for the new unified training grade are likely to insist on higher specialist training in addition to scientific training which will result in training taking three or four years longer for those undertaking research than for those following the normal hospital career path. There is nothing new in that you may say, but, of course, Calman gives a different context within which that is happening. We get the impression that the Medical Research Council and the Association of Medical Research Councils appear to be endorsing this model and it is likely—this is not a complaint, it is just a recognition of the situation—that as a consequence the longer training required to achieve the CCST will act as a disincentive for those considering undertaking research. Under the new system of National Training Numbers those undertaking research are, we understand, likely to preserve their numbers and, therefore, their place in the system regardless of whether or not specific quotas are introduced. The idea, we understand, of the numbering system is to ensure that we match the number of those in training to the projected requirements in the specialty concerned and, therefore, by maintaining that number those in research become part of the equation, their numbers can be matched to career prospects, with some eventually, if they wish, pursuing a career in academic medicine, others normally in the hospital system. Therefore, we feel that there is no need for a special quota in addition to the proposed numbering system as the proposed system should take account of future requirements. In relation to the unified training grade, we would reiterate that any research undertaken within the new grade must be done as a result of genuine personal commitment to completing a period of research, not as a requirement for furthering individual careers. At the same time, a period of research must not be seen as unnecessary “time out”—there is an old feeling that this has been unnecessary—which could later damage career prospects, particularly as we would wish to emphasise that for all doctors a good working knowledge of research methodology is an essential skill, especially in the future.

1377. It has been suggested to us that sometimes people may step aside deliberately for even longer than three years to do a PhD and that is something which the academics in training would no doubt regard as being wholly acceptable. A proposal has been made that those who do step aside will leave a vacancy, they will take their number with them and that that vacancy can only be filled on a locum basis by a visiting registrar. That seems to be a problem. Do you see an alternative means of handling that situation?

(*Dr Armstrong*) As long as they retain their training number and that number is matched to an eventual need, then whether they are out of the system for two, three, four or five years seems irrelevant. There is no essential difference between being out for one year and being out for four years.

21 March 1995]

DR A W MACARA, PROFESSOR J B L HOWELL
DR P DANGERFIELD AND DR E M ARMSTRONG

[Continued]

[Chairman *contd.*]

1378. It is an issue that I think we need to explore and also the question as to whether there should be a protected number of these for those aspiring to an academic career, as indeed I think you support.

(*Dr Macara*) Absolutely. Our anxiety would be maximum flexibility together with encouragement for all young doctors to take opportunities to pursue research but not only within established programmes. They need to be encouraged to follow their bent as we have always done with very important results.

1379. You have already commented on the importance of the NHS establishing a task force on clinical academic careers and I think we are aware of your views about locally negotiated pay. Do you wish to add anything on the question of equal pay for doctors in the NHS on the one hand and clinical academics on the other? Has it been undermined already? How will it be applied within the NHS as the pay issue is progressively devolved to trusts?

(*Dr Dangerfield*) I think the big problem here is that there is a principle of equal pay between doctors in the NHS and the university which must be maintained. If you lose that principle and lose that linkage I can only predict disaster. This link has been preserved as an established translation between the two sectors for many years and must continue into the future. The university's employers have never let us down, they have always made sure that the DDRB awards to doctors and dentists are implemented to the clinical academic sector as recommended by Government. I think the difficulty we perceive today is that for various different reasons the award is consistently delayed and this causes a loss of morale as Dr Macara has already alluded to. This year, for example, the request looks as if it is going to be delayed yet again and is already causing grass-roots concerns because of management wishing to negotiate with other groups of academic staff before moving on to translate what is rightly due to clinical academics. These negotiations will not take place until the higher education funding councils have allotted appropriate funding and universities assess their ability to pay. I think this is an important point. The employers, therefore, feel that they cannot negotiate on one group, i.e. the clinical academics' pay, until they have sorted out the other lot which is the rest of the universities. The rest of the universities are the people that are doing basic research and they do include medically qualified people; of course, but since they are not clinically employed, therefore they are on the same pay scale. I think it highlights the problem of disparity between a clinical career and a clinical salary and that of research people which is unfortunately, we feel, rather low and really should be addressed. It is a serious issue. It is the delay in translation that is the big problem here. I think this is an important point because it consistently creates this uncertainty to act as a disincentive for any doctor clinically qualified to take up a career in academic medicine. It again underlines your suggestion, which we welcome, to look into the whole way a career in academic medicine is followed because undoubtedly this is a major factor affecting recruitment into medicine and research.

1380. Do you think that trusts which are probably going, with the disappearance of the regions, to be more involved in the funding of clinical academic posts will be likely to maintain that parity?

(*Dr Dangerfield*) It is very difficult to know because it depends on whether the trusts value the kudos of research as a major factor in their work or not. They are basically driven by the costs of treating patients and their income is derived from treating patients. Are they that interested in people who perhaps are spending a lot of time doing research at the end of the day? The other side is that a number of clinical academics have posts and are employed in several or more trusts at once and this again is a big problem. Who do you negotiate with? You have your university to negotiate and you may have half a dozen trusts to negotiate with.

Lord Perry of Walton

1381. If the trusts get the power to fix their own scales of pay the university gets into an impossible position in maintaining parity with them all?

(*Dr Dangerfield*) Absolutely right.

Lord Flowers

1382. We are all of us talking as if there is a principle of equal pay for NHS doctors and clinical academics. There has been a practice, but I do not know what the principle is. Can you defend the principle?

(*Dr Macara*) I do not think we feel it is in need of defending. It may need explaining.

(*Dr Dangerfield*) I think it needs explaining because the young person going into medicine today is really looking at a training which is going to lead them on as a doctor treating patients, but on the way up to that, and rightly so, a lot of people are attracted by the inquiring mind into researching something and these are the people who we need to attract and to do this maintain the attraction of academic medicine. However, if you say to them, "Well, if you go and do that you are not going to be paid as well as your colleague who is doing the same job as you in the hospital", but it just so happens that you are doing research, I think you undermine the whole basis of medical academic practice in the long-term. Although there is no principle, it is just a happening, I think this is an essential principle to maintain.

1383. But we have had some evidence that what the bright young research doctor wants is good facilities rather than equal pay?

(*Dr Dangerfield*) Yes, they certainly will want good facilities, but if the NHS is deciding to push money into certain dedicated pathways to make sure that there is adequate resource to investigate thoroughly particular targeted areas we would hope and pray that the facilities accompany these things. At the end of the day I think you still must take note of the fact that we live in a materialistic world today and although the idealist in me would say, yes, research money is irrelevant, reality says we have all got to live. I think this is a very important point.

21 March 1995]

DR A W MACARA, PROFESSOR J B L HOWELL
DR P DANGERFIELD AND DR E M ARMSTRONG

[Continued]

[Lord Flowers *contd.*]

1384. That does not sound much like a principle to me.

(*Dr Macara*) With respect, I would submit that there are two principles. The first principle is that of equity, that young people committed to a career in medicine and wanting to maximise their potential, as they should want to do, should not have unequal rewards depending on whether they are currently engaged in clinical work or in research work, especially as it is particularly difficult in this field to make a distinction between medical practice, clinical work and research. That is one principle. The other principle is the pragmatic one of ensuring that we are able to enable the best people to be deployed where they are most needed in the interests either of research or of patient care, and some of us are old enough to recall that before what we regard as the principle of parity was established in I think the late 1960s (I think it was 1968) we had a major crisis not just of academic research work other than in centres of excellence but in relationships between university medical schools and the National Health Service. We would be very reluctant to see that destroyed as it would be, of course, by local pay arrangements. We are anxious to preserve the advantages of a unique system which we have benefited from in this country for the last 25 years. The value of the principle has been the way in which it has worked. Professor Howell may have something to add as a former dean.

(*Professor Howell*) Only to agree with what has been said. Perhaps I could take this question of principle. Clinical academics are different from most other equivalent stage academics in other faculties because they have a service to give which is roughly of the same order of magnitude as their NHS colleagues. That is a part of their lives and that they accept. There are some exceptions. The idea that one could expect them to have a broadly different pay structure I think would deter them from entering that career. We are arguing that consultants in different disciplines should have pay parity roughly the same. There can be adjustments to that, and I would have thought that the same principle applied to the clinical academic. It is the same type of work, but instead of doing private practice, or whatever else they wish to do, they are doing academic work, teaching and directing research. Usually by the time they become reasonably senior they are directing rather than doing the research. I have no doubt that I would defend pay parity between the academic and the NHS.

Chairman

1385. Could I ask you whether you feel that there is a case to be made out in the NHS and in the profession for spending time on educating trust chairmen and managers not only on the virtue of funding academic posts from NHS money, because we know that that leads very often to an enormous improvement in the quality of the service that is provided in those disciplines, but, secondly, to teach them about the virtues and the outcomes of research which all too often even at a basic level ultimately lead to major developments in patient care?

(*Dr Macara*) We would very much welcome that imaginative suggestion, my Lord Chairman, and practical means for implementing it. I think it would be right to say that the Association is in discussions with the organisations which represent both the managers and the chairmen not only of trusts but of the purchasing authorities as well which it would be equally important to include in this imaginative initiative, and certainly I have the impression that they would themselves welcome an opportunity to learn more about the potential for improving the quality either of the service they purchase or provide through an understanding of the way in which they can help us to do the right kind of research. It is a splendid idea.

1386. One means, of course, that has been used to recognise that there are differences between the different specialties and that there are differences between those who are involved solely in clinical service even at the highest standard and those involved in carrying forward the advancement of medicine on the other has been the distinction award system. You are negotiating on the Kendell report, we understand, with the health departments. What do you see as being the future of this? Will it make it more difficult for clinical academics to earn the C award or its equivalent, or will they, if they are quite outstanding, be able to jump straight to the B award?

(*Dr Macara*) My Lord Chairman, I will have to ask you to bear with me in rehearsing perhaps a bit of the background of the current situation concerning distinction awards because I think this is of very considerable importance. The Working Party which the Minister of Health set up to review the working of the awards scheme following substantial pressure, of course, from within Government and other organisations for the abolition of the scheme had completed its work in March 1994, but it was published only in October last year and then only without the Government's endorsement. The Minister made it clear then that, "The current arrangement for distinction awards should be retained for one more year but only on the basis that this will be the last year in which these arrangements apply." I should make it clear that the Association welcomed the Kendell report as offering a possible way of addressing the anomalies and frankly the inadequacies in the present system but retaining a scheme which would reward truly professional excellence, but which might at the same time conveniently resolve the dispute with the department over local pay in as much as there appears to be no reason why at least the C awards, which is normally the way at the moment, should not be determined at a local level. We have had intensive discussions and they are continuing. It is becoming clear that any scheme that is agreed will probably not relate closely to the Kendell report. It is likely that you will probably find a scheme which will feature a range of incremental points above the maximum of the consultants' salary scale and which will be more broadly based and involve more people than the current C award. It is not, on the other hand, envisaged that the higher awards will be affected by that scheme. We note also that it is likely that the criteria for progression up the new incremental scale

21 March 1995]

DR A W MACARA, PROFESSOR J B L HOWELL
DR P DANGERFIELD AND DR E M ARMSTRONG

[Continued]

[Chairman *contd.*]

will be based broadly on those which Kendell envisaged for the C award. An undertaking has been given to us that honorary contract holders and those clinical academics of whom we are speaking will be included in the scheme, although, so far as I am aware, details have yet to be discussed. You asked a question as to whether Kendell would make it harder for clinical academics to earn a C award. As it is unlikely that Kendell will be implemented in its original form the question may be somewhat academic.

Lord Nathan

1387. I am very interested, Dr Macara, in point 11.1 in your memorandum on primary and community care. As far as research is concerned, you refer to the fact that there are few details as to how the development of a research infrastructure will be achieved. Have you a view as to how it should be achieved and, secondly, have you any view as to how and whether curiosity-driven research should apply in this area as in the more traditional areas of medical research?

(*Dr Macara*) There is no question whatsoever about the answer to your second question, my Lord, which is, of course, no less. Curiosity-driven research must apply no less in the community and primary health care arena as in hospitals and university departments. To answer your first question I think we could draw upon Dr Armstrong's recent experience in general practice and as one who undertook research in general practice.

(*Dr Armstrong*) The Association is now wholeheartedly supportive of the concept of merit awards to clinical academics who are engaged in research in general practice and teaching in general practice. We would, however, wish to see this funded through an extension of the merit award system rather than from a system which depended on the money coming from within the pool of target net income for general practitioners themselves. There is a pool system for the remuneration of general practitioners and if the merit awards were funded from within that pool it could only have the effect of rewarding clinical academics in general practice at the expense of their colleagues who were not academics, and that is not, I am sure, the purpose of the scheme. It is in fact the case at the moment, for example, that the teaching of medical students by general practitioners in general practice is funded from within the pool of money which is available for the provision of clinical general medical services, so we would support the availability of merit awards for academic GPs but by an extension of the merit awards system.

Chairman

1388. One possible arrangement would be a division of the R&D budget of the Department of Health into three streams. Within the expanding percentage which we hope will be allocated to this initiative, one would be used for the funding of centrally commissioned research, Professor Peckham's initiative, the Department of Health

units, but also the initiatives that are being proposed by the Central Research and Development Committee. A second stream might be used for similar R&D initiatives at a regional level based upon the priorities set by the regional directors of research and development, and the third component would be the facilities and infrastructure funding for basic research and curiosity-driven research in the hospitals, etc. That is one possibility. It has been suggested to us that money in the second stream at regional level might be used, among other things, for the support of research general practices, like the initiative that has been funded by the Royal College of General Practitioners which has given supplementary funding to allow certain general practices to engage in research or, alternatively, to fund research sessions for general practitioners on application. Equally, of course, it could be used to fund fellowships for GPs, but also for nurses, midwives and others working within all the professions complementary to medicine. Is this sort of initiative one that would commend itself to the Association?

(*Dr Armstrong*) Yes, my Lord Chairman, we would support all of those initiatives.

(*Dr Macara*) My only further thought, and this is, of course, off the cuff, is that the regional director of research and development would require a great deal of wise support in deciding between what I would hope would be a great many competing claims for support.

1389. One thing that has been put to us by many witnesses is the need to maintain the regional locally operated research schemes which are the way in which many young people take their first steps in research. It has also been suggested under the terms of the Health Authorities Bill that regional consortia will be established and will involve all the universities and all other relevant people to look at such provision at a regional level.

(*Dr Armstrong*) One of the continuing uncertainties, of course, my Lord Chairman, is the uncertain position of the academic structure at regional level which supports general practice through the postgraduate deans whose future is uncertain, the regional advisers of general practice whose future is uncertain and their associate advisers. All of that is up in the air. Therefore, until we know what structure is proposed from them we will not know how that structure will relate to the regional directors of research and development who will be essential in bringing this matter together.

1390. In the debate on the Second Reading of the Health Authorities Bill my recollection is that we were given assurances that the regional postgraduate deans would continue in office employed jointly between the universities and the regional office and so, too, would the regional advisers in general practice, so that that particular structure, we hope and believe, is to be preserved, but it is an issue upon which we will be seeking further assurances.

21 March 1995]

DR A W MACARA, PROFESSOR J B L HOWELL
DR P DANGERFIELD AND DR E M ARMSTRONG

[Continued]

[Chairman *contd.*]

(*Dr Macara*) It is one on which, as I have said, we are making personal representations to the Secretary of State.

(*Dr Macara*) Thank you very much, my Lord Chairman.

1391. We thank you very much for coming and being willing to give evidence to us.

WRITTEN EVIDENCE

Evidence from the Arthritis and Rheumatism Council

The Arthritis and Rheumatism Council is a charity, relying entirely on voluntary donations, the aims of which are to promote research and education in the field of rheumatic diseases. During the year 1994 the ARC awarded £15.7 million to doctors and scientists undertaking arthritis research. The Council has an ongoing research commitment of £33 million. The clerk to the House of Lords sub-committee has indicated that the views of the ARC are sought about three main matters:

- (1) an assessment of the NHS R&D strategy;
- (2) a response to the Culyer report; and
- (3) additional challenges or opportunities for UK medical research which neither the NHS strategy nor the Culyer Report addresses.

(1) THE ARC ASSESSMENT OF THE NHS R&D STRATEGY

1.1 The NHS R&D strategy has been focused on the priority areas identified in the Health of the Nation document. Priorities have been set by a process of consultation in many areas of health care and a commissioned programme of research is just getting under way. The ARC considers that it is premature to evaluate the outcomes of this programme of work.

1.2 The ARC wishes to express three areas of concern about the development and implementation of the NHS R&D strategy:

1.2.1 There has been an appropriate desire to get the NHS R&D programme off to a rapid start but this has led to problems in the process of commissioning research. The commissioned programmes of research have been advertised with short deadlines for response, which may not allow applications of the highest quality to be prepared.

1.2.2 The ARC is concerned that the commissioning of research may be at the expense of funding for spontaneous proposals.

1.2.3 The ARC considers that there is a danger that research may be commissioned into the solution of intractable questions, either because methods are not available to address the clinical problem or because appropriately trained or interested investigators may not be available. In these cases there may be a danger of spending R&D funds on second rate proposals by default.

1.2.4 The justifiable desire to demonstrate the effectiveness of the NHS R&D programme may encourage an emphasis on work which will yield results in the short term. Many of the rheumatic diseases are chronic conditions where a long term approach may be essential to evaluate substantial clinical changes. Furthermore, "short-termism" may encourage work at the development end of the R&D spectrum at the expense of discovery of novel approaches to the assessment and management of disease.

(2) THE RESPONSE OF THE ARC TO THE CULYER REPORT

The ARC welcomes the main thrust of the Culyer Committee report and the accompanying response by the Secretary of State for Health. In particular:

2.1 *Ring-fenced funding for research and development*

The Secretary of State's commitment to ring fenced funding for research and development and her determination to increase the amount available in subsequent years for R&D is particularly welcome, as was her acceptance for a national R&D strategy involving the MRC, the Medical Research Charities, HEFCs and industry.

However it is clear that, in the first instance, there will be no new money and that there will be a redistribution of resources. The funds at the disposal of the new programme will be drawn principally from the "R" component of SIFTR, the central NHS R&D funding of the ex-SHA London Postgraduate Hospitals and other identifiable NHS R&D funds. This may create substantial problems for the Medical Schools and ex-SHAs. If there is a significant withdrawal of funds (particularly infrastructure support) from those trusts supporting undergraduate and postgraduate medical schools, this may jeopardise the national R&D effort. Part of the problem addressed by the Culyer report is the funding of research which takes place in General Practice. The ARC considers that the fostering of worthwhile research in General Practice is a high priority but the NHS reforms, leading to the creation of large numbers of semi-autonomous fund-holding general practitioners is unlikely to promote an atmosphere in which research will flourish. The ARC considers that part of the levy that makes up the total R&D fund should come from the FHSA's and fund-holding general practitioners' budgets.

2.2 *Maintenance of the Research Infrastructure*

The ARC recognises the potential advantages of diversifying the environments in the NHS within which research and development is conducted. However, using HEFC criteria the most highly rated biomedical research in the UK is currently performed in multidisciplinary clinical and scientific institutions and these appear to be a highly successful model for biomedical research world-wide. The ARC commends the concept of infrastructure support which is a feature of the Culyer proposals.

2.3 *Clinical Research and Health Services Research*

2.3.1 The ARC recognises the relative neglect of research into the quantification of health care needs and the delivery of health care. However it is concerned that the remedy of this neglect may be at the expense of long term basic curiosity-led research into the pathogenesis of disease. The ARC expects that NHS R&D initiatives will highlight common clinical problems, which include a number of the rheumatic diseases. There is substantial ignorance about the aetiology and mechanisms of many rheumatic diseases and major advances in understanding and treating them will require a substantial continuing investment in basic research. The ARC considers it of the highest importance that NHS R&D funding provides an infrastructure to support such work, which is most likely to flourish in environments where there is an intersection between the clinic and the laboratory.

2.3.2 The ARC is especially concerned that progress in understanding and treating the chronic rheumatic diseases will require the clinical follow-up of substantial cohorts of patients for prolonged periods. With an increasing proportion of fund-holding general practitioners and purchasing agents with primary loyalties to local hospitals, it may prove very difficult to assemble cohorts of patients with specific rheumatic diseases. Moreover, purchasers may be unwilling to pay for the costs of their regular follow-up over prolonged periods of time. This problem was not addressed adequately in the Culyer report.

(3) **ADDITIONAL CHALLENGES OR OPPORTUNITIES FOR UK MEDICAL RESEARCH**

The ARC is concerned that there are a number of threats that arise from the unravelling of the traditional partnership between the NHS and clinical research.

3.1 The creation of purchasing agencies with powerful local interests has resulted in a reduction in the free flows of patients between hospitals. This may have important benefits of patients in the development of local services for the treatment of common conditions. However, it also threatens the referral of patients between hospitals which may create difficulties in recruiting patients to research protocols, as outlined above in paragraph 2.3.2.

3.2 Whilst purchasers and fund holding general practitioners may pay lip service to the importance of sustaining research, they are unkeen to pay for it. This creates difficulties in the conduct of clinical research programmes. This issue is of particular concern to charities such as the ARC. Traditionally the NHS was a willing partner with the medical research charities in the conduct of clinical research. Now the charities are being asked to pay for much of the service infrastructure for research, which will radically reduce the number of projects that they can afford to support. The ARC would like to see a concordat developed between the medical research charities and the NHS which is similar to that between the MRC and the NHS.

3.3 The introduction of a unified training grade following the Calman report may have a very damaging effect on the NHS R&D effort:

3.3.1 The reduction in trainees with a compensatory increase in consultants will substantially increase the service demands on already hard-working consultant and clinical academic staff which will reduce their ability to participate in research. It is unlikely that the HEFC will create an increased number of senior lecturer posts to compensate for the reduction of senior registrars and registrars on academic units. Transfer of some of the money saved by the reduction in the number of trainees into academic posts, in addition to the expansion of the consultant grade, would help in respect of this problem.

3.3.2 No clear solution has yet emerged following the Calman report on the mechanisms for the training of the clinical academics of the future. Problems which may occur are: (i) that a bottleneck in the training grades is likely to develop immediately prior to the entry into the unified training grade. This may result in pressure on junior doctors to obtain research training at this point in their career. For an aspirant clinical scientist, this may mean that three years of training for a PhD may be followed by up to five years of clinical training to obtain a mandatory certificate of higher training. This prolonged period of full-time clinical training, rotating through several hospitals, following a basic research training may prove a serious impediment to the re-establishment of a research career. (ii) Alternatively a trainee may rotate out of a clinical training programme to conduct their research, as effectively happens at present between registrar and senior registrar grades. In this case, it is not clear what will happen on the clinical training rotation. Will this lose its training number and result in substitution of a "non-career" locum? If this were the situation, rotations which attract the strongest academic candidates may almost perpetually be filled by locums. The alternative, of filling such clinical rotations with another academic trainee, will have significant manpower implications. (iii) The rigorous demands for clinical certification may result in a very significant training time penalty for aspirant clinical academics. It is generally recognised that the minimum basic period of research training for an academic is three years. Even allowing for the recognition of one year of research training as part of the clinical programme of training, it will take an additional two years for a clinical academic to achieve a career position. Training should be defined in terms of required knowledge and skills, and the acquisition of these should be the criterion for accreditation. It must be recognised that the time required will vary between individuals.

Evidence from the Association of British HealthCare Industries

In responding to the three questions raised in the Call for Evidence, we feel that the ABHI should represent the views of the medical device industry and what the medical device industry seeks from UK's medical research.

The medical device industry's principal requirements of NHS R&D activities are threefold:

- I. A source of new medical techniques and product ideas;
- II. Work to demonstrate the effectiveness of the new techniques identified;
- III. Assessment of the cost effectiveness of products and services which can demonstrate their value and also highlight areas where improvements would be most beneficial. It is expected that this would arise largely out of widespread investigations of outcomes of the use of various alternative therapy regimes.

These requirements provide the background to the responses below.

1. WHAT IS YOUR ASSESSMENT OF THE NHS RESEARCH STRATEGY?

- (a) ABHI welcomes the emphasis of the R&D Strategy on producing the information essential for the operation of a knowledge based health service. In particular, we are pleased to see the emphasis on assessment of cost effectiveness of treatments and services.
- (b) We welcome the setting up of a strategy which can direct research activities in a more co-ordinated way to achieve these goals.
- (c) We are concerned at the potentially heavy onus on the Regional Directors of R&D. They will have a considerable co-ordinating task in bringing their influence to bear not only on the objectives of the programmes but also on the actual direction in which work progresses. We feel that much research has been carried out by highly motivated individuals who have either some particular scientific preoccupation, or who have a vested interest in maintaining their own line of activity irrespective (as far as possible) of outside influences.
- (d) Our experience is that there is often poor communication between researchers in related fields. We have frequently found researchers who are totally unaware of similar work being carried out. In many cases, basic background literature searches have not been carried out adequately. This suggests a lack of fundamental research competencies among those who are most motivated to do such work. We are also concerned at the apparently slow progress in establishing the "NHS R&D Project Register": we feel strongly that industry should be able to access this information.
- (e) In imposing a structure on the R&D activities carried out in the NHS, we would not wish to see a reduction in the initiative or capacity of individuals to undertake research activities. Difficulties resulting from the current NHS reforms are clearly laid out in sections 2.7 to 2.12 of the Culyer report. We are concerned that in imposing a clear sense of direction into the areas of work where priority is highest, there is a danger that bureaucratic mechanisms may be imposed which stop small but highly productive research projects from starting, and could make other useful programmes too large and academically rigorous.

- (f) Motivations of researchers are a key factor in the success of this strategy. Experience in many fields shows that real progress often results from diversity. This allows the breakthrough technologies to be pursued and investigated. We are concerned that the mechanisms of an over rigorous R&D policy could discourage a number of those who have contributed much to research in the past, potentially reducing diversity to an extent that the NHS would become less innovative. As a consequence, UK industry could be less likely to come up with innovative products for export to the rest of the world.
- (g) One impact of the NHS reforms is an increasing focus by providers on measurement of the cost of the various activities they undertake. We would like to see steps being taken to make more effective use of the information resulting in every institution to provide a more informed basis on which decisions can be taken. This implies that a positive step should be taken to encourage wide ranging but small scale research activities in all departments throughout the NHS. To do this, the basic research competencies need to be available and there must be time available to staff to carry out these assessments on a regular basis. Finally, there needs to be a mechanism for staff carrying out such work to be able to communicate effectively with others in a similar position to be able to establish consistency, and to swap information and insights as quickly as possible. We are concerned that issues of Trust commercial confidentiality may get in the way of this to the detriment of the NHS as a whole.
- (h) We welcome the establishment of the Standing Group on Health Technology to review the Health Technology Assessment panels. However, we are concerned that these panels do not have the capacity to meet any more than a tiny minority of the requirements which industry would ideally have of them. We would further like to know if this Standing Group is intended to fulfil the role of the "NHS Industry Research Advisory Group" tabled at the meeting on Industry and NHS Research & Development on 26 April 1994.
- (i) We are sorry to see that, although industry was mentioned briefly in the Research for Health paper of 1993, it does not rate a mention in the 1994 review. We would like to see the development of a partnership attitude between the NHS and industry in the area of R&D and technology development; this could mean involving industry in the Regional R&D networks and relative openness in terms of information on activities and outcomes. While this may require a change in the understanding by industry of its duties and responsibilities in using such information, we believe that this is a change which would be recognised by all involved as well worthwhile.
- (j) We welcome the formation of the new MEDLINK programme as an indication that the DoH recognises the essential role of industry in providing new technologies for the NHS.

2. *What is your response to the Culyer report on "Supporting Research and Development in the NHS"?*

- a. ABHI welcomes the Culyer report's proposal to provide specific funding for the R&D strategy, and the fact that the Government has acted on that recommendation.
- b. In the light of comments above about balancing lightness of touch against maintaining a strategy, we are concerned that the centralisation of such a budget should not lead to an over-bureaucratic system of allocating the budget.
- c. In the context of the NHS reforms, we are concerned that if all research is specifically funded, there could be an increasing divide between those doing research and routine clinical practitioners. This could have a tendency to reduce the assessment of newly available data rather than increase it, and could also reduce commitment at an operational level to an information based service.
- d. Industry welcome the establishment of industry representation in the CRDC and the newly created National Forum. We trust that industry representation will be sufficient to address our concerns expressed in para 1(i) above.

3. *Do you identify additional challenges or opportunities for UK medical research which neither the NHS Strategy nor the Culyer report address?*

- a. Industry's principle requirement of industry in NHS R&D activity is laid out at the beginning of this submission. In particular, industry would like to see improved access to cost and market information in the NHS. In addition, we would like to see an initiative along the lines suggested in the ACARD report on Primary Care (Appendix A, para D).

Evidence from the Association of Medical Research Charities

THE CHARITIES CONTRIBUTION TO MEDICAL RESEARCH

1. The Association of Medical Research Charities represents 79 member and affiliated charities. Their contribution to United Kingdom medical research has grown steadily in the past 10 years and in 1992-93 amounted to £269 million (Table 1).

2. The Association believes that proper assessment of research funding is most important. A criterion for membership of, and affiliation to, the Association is that charities must use peer review in the allocation of grants and awards for research.

3. Medical research charities exist for the primary purpose of improving health through supporting research: an aim which is in the public good and is purely philanthropic. Their purpose in funding research is not for corporate or individual gain but to prevent or cure disease and ease human suffering and it is the NHS's patients who benefit.

4. The work which research charities support is undertaken largely in institutions which are themselves mainly funded from government sources: Higher Education Institutions (HEIs) and NHS Hospitals with the far higher proportion going to universities (Chart 1).

5. Within these institutions charities rarely direct or commission research: their contribution is largely in the form of responsive support for research for which HEIs, their staff, or NHS staff seek funding. This funding might be in the form of projects, programmes, fellowships, pump-priming and occasionally entire units or departments. Such support differs very substantially from commercially commissioned or funded research.

6. It must not be forgotten that most individuals who are funded by charities to do research also undertake teaching and other responsibilities within HEIs, and clinical duties within the NHS. Charities within the Association are currently funding 127 Consultants, 116 senior registrars and 246 registrars all of whom undertake some clinical work for the NHS in addition to their research duties. The Association believes that the charities' contribution to medical research should be viewed as similar in purpose to that of the Medical Research Council and should not be likened to commercially funded research.

7. The majority of medical research charities raise money from the general public and support research into a single disease or group of diseases. Their contribution to medical research should be understood within the limits set by their individual charitable objects. Charities are not free to redirect their support to areas which may be seen by some as having a higher priority but which are outside their own charitable objects.

THE NHS

8. The NHS is a vital partner in the UK medical research enterprise. As a national health service it has provided an excellent environment in which all types of clinical research could be developed and could thrive.

9. The Association has been concerned for some time at the fragmented way in which decisions regarding the medical science base are made. There has been a period of almost continuous major change and instability in the NHS during which the needs of medical research have appeared to have had a low priority. The Association welcomed the establishment of the Research and Development Division within the Department of Health which it believes has made an important contribution towards fostering a research environment within the NHS. The new Task Force is a timely opportunity to focus on the needs of medical research within the NHS.

10. The NHS internal market has introduced different pressures and thinking in which research seems not to have a high priority. Purchasers find it difficult to consider the medium to long term requirements or benefits of research in competition with short term needs.

11. Continuous administrative changes are resulting in a fragmentation of priorities. As the move towards greater local decision-making takes place the Association is concerned that the priorities for medical research, which is essentially a national enterprise, will be lost. In the majority of instances, national research needs will differ from local research priorities. The NHS must retain an ability to establish and support research activity on a national scale.

REQUIREMENTS OF CLINICAL RESEARCH

12. Clinical research requires qualified staff and access to patients, clinics, beds and other hospital related resources.

13. Clinical research requires individuals to be trained in research. The NHS must continue to provide an environment in which clinicians may acquire the skills required to undertake good quality research. Any mechanism for manpower controls must be flexible; it must allow trainees to take up research training opportunities and enable scientific knowledge to be carried through to the clinical environment.

14. Clinical research requires appropriate concentrations of patients together with scientific and research expertise. This is true for relatively common diseases, such as breast cancer, and also for rare conditions where

concentrations of patients are often hard to achieve. Many centres of excellence have seen their patient referral numbers drop dramatically, some to such an extent that the continuation of research programmes is threatened. Action must be taken to protect the flow of patients for clinical research.

15. Patterns of patient referrals have changed following the introduction of the internal market and further change is anticipated, particularly in city centres, where older hospitals are expected to close. The problems in London are particularly acute where several of the centres identified as candidates for closure are also nationally and internationally important for their research. In particular, the funding for referrals from fund-holding general practitioners requires consideration.

17. The introduction of the internal market has led to problems in the funding of the additional costs of patient care associated with research. In particular, several member organisations report potentially serious difficulties associated with clinical trials. There is a need for a funding mechanism which will protect the continued support of research in the NHS.

18. Charities usually meet the direct costs of research (full-time research workers, equipment, consumables) and the universities and NHS would normally be expected to meet the infrastructure costs. In the NHS these costs were meant to have been covered by the SIFTR allocation and the Association believes it is inappropriate for charities to be asked to meet such service expenses.

19. There should continue to be strong links between the academic and research institutes and NHS hospitals reflecting the important contribution each sector makes to the other's activities.

FUNDING FOR RESEARCH

20. There are several components necessary for the proper funding of clinical research in the NHS. Firstly, the service costs associated with the research must be met. Secondly, there needs to be some infrastructure funding to generally support the research environment and thirdly there needs to be specific funding to support the costs of the particular research. It is the Association's understanding that SIFTR was intended to cover the first and second components, and funding from external bodies (charities, NHS Research and Development, MRC etc) supported the third.

21. The NHS should continue to differentiate between funding for service support costs and funding for particular research programmes.

22. The Association believes it is important that the mechanism for disbursing government resources for the support of medical research should reflect the fact that research is a national enterprise. The majority of medical research charities have a broad remit and are able to support excellent research wherever it may be carried out in the UK. The Association is particularly anxious that mechanisms for the distribution of national resources for medical research should be based on peer review, should minimise unnecessary duplication and foster excellence.

23. SIFTR has been allocated to regions on the basis of undergraduate student numbers. The Association believes that this is a poor proxy for medical research activity and that the system has resulted in substantial difficulties for some regions where research activity is high. The Association makes the following proposals for changes to the way in which SIFTR is allocated.

- (a) The funding of the service costs of research should be separated formally from funding for the service costs of teaching (as recommended by the Tomlinson Report). Research funds should be identified as clearly as possible at each stage of the allocation (from centre to regions, from regions to hospitals, from hospitals to clinical researchers);
- (b) Allocations of the funds for service support from the regions to hospitals (which the Department of Health cannot dictate) would need to take account of advice from research interests including the charities;
- (c) The system for allocation of service support for research could be formula based. The system must be flexible enough to take account of changing volume and patterns of research activity and to respond to opportunities. There are a number of volume measures that might be considered, for example peer reviewed research income;
- (d) The system should be accountable and capable of monitoring, be easy to understand and to administer;
- (e) Any new system should ensure the effective targeting of funds with allocations related as closely as possible to actual service costs incurred within the NHS;
- (f) The system should take account of the need for there to be a degree of stability for both academic and hospital funding in order for research to thrive;
- (g) The system should cover all hospitals regardless of how present service costs of research are met (either SIFTR, SHAs, non-SIFTR scheme) and should include primary care;
- (h) The complexity of disentangling teaching and research costs should not delay the introduction of a change and transitional arrangements should be considered once a commitment to change has been agreed.

24. The Association believes that there needs to be further discussion about the size of the NHS research budget. One possibility would be to take the current estimate of approximately 25 per cent to 30 per cent of SIFTR, plus the special fund for non-SIFTR hospitals, the appropriate proportion of SHA funding and some modest additional resources to support research in primary care.

5 February 1994

Submission to Chancellor of the Duchy of Lancaster on the future of UK Science and Technology

SUMMARY

1. The Association of Medical Research Charities represents 72 member and affiliated charities. Their contribution to United Kingdom medical research has grown steadily in the past 10 years and in 1991–92 amounted to over £240 million.

2. The Association believes that proper assessment of research funding is important and a criterion for membership is that charities must use peer review in the allocation of grants and awards for research. The Association believes that the charities' contribution to medical research should be viewed as similar in purpose to the Medical Research Council and should not be likened to commercially funded research. (1.3)

3. In spite of the fact that medical research in the UK is a partnership between HEIs, charities, industry and government thinking about the needs of medical research at government level appears to consider only the needs of government funded agencies and not the wider environment. The charities seek more formal recognition of their role and an input into decision-making. (2.5)

4. The Association hopes that with the establishment of an Office for Science and Technology there is an opportunity to consider the needs of research at every level of planning and at a practical level. It would like to see the establishment of a standing committee which would bring together those sectors with an interest in UK medical research. (2.6)

5. The Association believes that dual support has been a successful and flexible mechanism for funding research in which a partnership between government, charities and industry has thrived. (3.4)

6. Charities do not intend to contribute to indirect or infrastructure costs on project grants which they regard as the responsibility of the HEIs and government who are the ultimate beneficiaries of this research. (3.4)

7. The Association believes there is a need to offer keen young scientists the opportunity of a career in research if they are to be attracted beyond the first one or two years after post doctoral research. (3.7)

8. The whole issue of retaining scientists in medical research (clinical and non-clinical) is of great importance and urgency and needs to be considered collaboratively by all those with interests in the science base. (3.9)

9. The Association believes that the UK is disadvantaged internationally by current laws regarding intellectual property. (4.1)

Submission to Chancellor of the Duchy of Lancaster on the Future of UK Science and Technology

The Association of Medical Research Charities welcomes this opportunity to put forward its views on how the UK could achieve the best results from its medical research base.

ASSOCIATION OF MEDICAL RESEARCH CHARITIES

1.1 The Association of Medical Research Charities represents 72 member and affiliated charities (Appendix 1). Their contribution to United Kingdom medical research has grown steadily in the past 10 years and in 1991–92 amounted to over £240 million (see Chart 1).

1.2 A criterion for membership of the Association is that charities must use peer review in the allocation of grants and awards for research.

THE CHARITIES' CONTRIBUTION TO THE SCIENCE BASE

1.3 Medical research charities exist with the primary purpose of improving health through supporting research: an aim which is in the public good and is purely philanthropic. Their purpose in funding research is not for corporate or individual gain but to prevent or cure disease and ease human suffering. The work which research charities support is undertaken largely in institutions which are themselves funded mainly from government sources: Higher Education Institutions (HIEs) and NHS hospitals (see Chart 2). Within these institutions charities rarely direct or commission research in these institutions: their contribution is largely in the form of responsive support for research for which HEIs or their staff seek funding: projects, programmes, fellowships, pump priming and occasionally entire units or departments. Such support therefore differs very substantially from commercially commissioned or funded research. It should not be

forgotten that individuals who are funded by charities to do research also undertake teaching and other responsibilities within HEIs and clinical duties within the NHS. The Association believes that the charities' contribution to medical research should be viewed as similar in purpose to the Medical Research Council and should not be likened to commercially funded research.

1.4 The Government will be aware of the enormously important, indeed crucial, role that charitable funding has provided for university based medical research, especially in recent years. The UK pharmaceutical industry is one of the strongest sectors in the economy: it too benefits greatly from the broad scientific base for medical research which has developed under the present funding mechanisms.

1.5 Charities are now the principal source of funding for research into many disease areas; they fund both applied research and research into areas of basic biomedical science valuable to all medicine. Even amongst single disease charities more than half of their research support can be in fields of basic medical science.

THE STRUCTURE OF DECISION-MAKING

2.1 The Association's principal concern is the fragmented way in which decisions regarding the medical science base are made. There has appeared to be a lack of consultation in planning and co-ordination of research policy during a period of major change in both the NHS and higher education. There is little evidence to suggest that an overall research strategy links various government programmes. The charitable sector has rarely been consulted or involved in discussions at an early stage. The Association would wish to see research needs considered in a wider environment, particularly in the NHS and has welcomed the establishment of the Research and Development Division and the appointment of its Director.

2.2 The Association notes that those with interests in UK medical research are rarely brought together and as far as we are aware this has never been achieved at the initiative of government. We are aware of many bilateral discussions involving just government departments or government funded agencies. An example of this is the MRC and Department of Health Concordat, regarding research in the NHS: no such consultation has taken place with the charitable sector which is of equal importance to UK medical research.

2.3 The charities value opportunities for collaboration with others. The Association has worked with the Medical Research Council to develop a closer working relationship in recent years as also have individual charities. The bodies share many concerns and contact between the organisations is regular although mainly informal in nature.

2.4 A plurality of sources of funding (including the MRC and the individual charities, industry and government departments) is beneficial to the science community and has produced an outstandingly strong environment for medical research in the UK. In particular, the partnership between government and charities in supporting research in HEIs has been an important factor in developing the breadth and strengths of university medical research.

2.5 In spite of the fact that medical research in the UK is a partnership between HEIs, charities, industry and government thinking about the needs of medical research at government level appears to consider only the needs of government funded agencies and not the wider environment. The charities seek more formal recognition of their role and an input into decision-making.

2.6 The Association hopes that with the establishment of an Office for Science and Technology there is an opportunity to consider the needs of research at every level of planning and at a practical level. It would like to see the establishment of a standing committee which would bring together those sectors with an interest in UK medical research. Such a committee need not infringe the independence of any of the participants involved. Many of the issues discussed in the remainder of this submission can only be tackled and solved with this level of leadership and sharing of common goals.

THE MEDICAL RESEARCH ENVIRONMENT

3.1 The medical research charities are concerned that the medical research environment in the UK has become increasingly unpredictable in recent years. The current period has been one of substantial change in both higher education and the NHS. For research to thrive the environment must be reasonably stable and predictable otherwise long-term planning cannot be carried out. Those partners in medical research should be kept fully informed of developments which are likely to affect the way in which they support research.

Higher Education Institutions

3.2 Whilst the Association appreciates the need for change it believes that the difficulties which rapid changes bring about for research funders has not been acknowledged. Changes in the funding of university research introduced in the last five years have created an unstable and uncertain environment for medical research funded by charities. Nearly 60 per cent of charity support is at present spent in universities across a wide range of subjects. The disintegration of the dual support system has meant that the concept of the well-found laboratory has had to be re-examined. This has led universities to seek to recover a greater proportion of their costs from charitable sources.

3.3 The HEFCE has proposed further changes in the structure of university research funding. The Association remains concerned that there is insufficient understanding of the possible impact of these proposals. The HEFCE plans regarding funding for research seem to be based on the premise that the government is the major source of support for project grants through the research councils. While this is largely true for many areas of scientific research it is not the case for medicine. Mechanisms which favour strongly the research councils will cause a corresponding disparity for researchers working in those areas of medical research which are largely dependent upon income from charitable sources, for example cancer and heart disease.

3.4 The Association believes that dual support has been a successful and flexible mechanism for funding research in which a partnership between government, charities and industry has thrived. The charities have responded generously to university initiated proposals for research and now support the full range of direct costs including salaries, consumables, small items of equipment and support staff. Charities do not intend to contribute to indirect or infrastructure costs on project grants which they regard as the responsibility of the HEIs and government who are the ultimate beneficiaries of this research.

Medical Researchers and careers issues

3.5 A broad range of professions are involved in medical research. The charities within the AMRC currently are supporting around 4,500 individuals in research including clinicians and basic scientists, support staff and professionals allied to medicine. The charities support senior appointments as well as training posts and short-term research posts. **Nurturing this principal resource of medical science—the people—is of the highest priority.**

Initial Steps

3.6 Medical research must attract sufficient numbers of able individuals from which to draw its career researchers and shorter term contributors. There is some evidence that suggests that science and medicine are no longer so attractive to school leavers and that good medical and science graduates may not be attracted to research. Part of the latter problem was undoubtedly linked to the poor remuneration given to postgraduate students: in 1988 the Association addressed this issue by recommending a minimum stipend for postgraduate studentships which now stands at £6,600. Although some PhDs are acquired through part-time study or whilst working as research assistants, the Association believes that a significant proportion should complete a period of full-time study. Members of the Association, although having a primary interest in research, have recognised the need to have a sufficiently large pool of scientists undertaking research training and now support some 200 PhD studentships in the UK.

Careers in research

3.7 The Association believes there is a need to offer keen young scientists the opportunity of a career in research if they are to be attracted beyond the first one or two years after post doctoral research. Major difficulties exist at this stage for both medical and non-medical graduates.

3.8 The paucity of long-term career posts in universities forces many researchers to continue their careers supported on a series of short-term appointments or to leave scientific research altogether. The balance between short-term funding and long-term opportunities appears to be wrong but the provision of long-term support presents particular difficulties for the “collecting tin” charities which, in general, fund grants from recurrent income rather than from endowments or interest on capital. For such charities five years is “long term” in financial terms. The few charities which are able to support research workers in the longer term (for example through “rolling” appointments or endowed posts) such as the Wellcome Trust, Imperial Cancer Research Fund and the Cancer Research Campaign, help to ease the problem but cannot overcome it. We would want to encourage charities who are able to do so to increase their long-term commitments, but Government must appreciate that the current uncertain situation in universities and the NHS makes this exceptionally difficult at the present time.

3.9 The whole issue of retaining scientists in medical research (clinical and non-clinical) is of great importance and urgency and needs to be considered collaboratively by all those with interests in the science base. The Association believes that a standing committee as suggested in paragraph 2.5 might take on this most urgent of tasks. In the absence of such a body, the Association will give consideration to the establishment of a national forum to consider careers issues within medical research.

3.10 Clinical medical research requires patients. Changes in patient referral patterns are undoubtedly occurring as a result of the introduction of market mechanisms in the NHS but it is perhaps too early to quantify their impact on research. The Association is aware that the concerns of the medical research community in respect of this issue have been noted by Government. In relation to London, where medical research charities spend approximately one third of their money, there is particular concern about current difficulties. It is appropriate here to comment on the need for swift decision making with regard to Sir Bernard Tomlinson's enquiry into provision of health care in London, if many London medical schools and teaching hospitals are not to be adversely affected by planning blight.

Management

3.11 In the past there was a close link between NHS management and those involved within the delivery of patient care: in this way an informal network and day-to-day experience of research needs and opportunities was built into the system. Today's senior NHS management is made up largely of non-clinical professionals whose experience does not perhaps give them the same knowledge and feel for research.

Manpower

3.12 Many doctors who will ultimately make their careers within the NHS spend a period of training in research funded by medical charities. We believe this is to the advantage of clinical medicine and should not be discouraged. Rigid manpower controls and lack of flexibility are detrimental to the development of research programmes.

OTHER ISSUES*Intellectual Property*

4.1 The Association believes that the UK is disadvantaged internationally by current laws regarding intellectual property particularly in the area of the human genome. This problem is not new and will need strong leadership from government to be resolved.

Technology Transfer in the NHS

4.2 There are special problems within the NHS which can slow the introduction of improvements in patient care which arise from research. The Association hopes that the NHS will consider the introduction of a communications structure which will recognise the time cycle necessary for planning.

European Community

4.3 The Association is aware that considerable resources are available through the European Community for scientific research and would like to see clearer information made available about the various schemes. A good, well resourced central point of contact is needed for the UK science community.

Public Understanding of Science

4.4 The medical research charities are concerned about mounting evidence that a climate antagonistic to science may be developing. Criticism of the role of science is often misinformed but nevertheless influential. The Association would like to see more attention paid by Government to its role in the public understanding of science including the proper use of animals in medical research.

APPENDIX 1

MEMBERS' AND AFFILIATES' EXPENDITURE ON BIOMEDICAL RESEARCH

<i>Name</i>	<i>Expenditure Tot</i>
Imperial Cancer Research Fund	£52,609,000.00
Wellcome Trust	£52,046,000.00
Cancer Research Campaign	£42,000,000.00
British Heart Foundation	£20,538,560.00
Arthritis and Rheumatism Council for Research	£14,904,000.00
Leukaemia Research Fund	£10,600,000.00
Ludwig Institute for Cancer Research	£4,215,000.00
Action Research	£3,903,000.00
Yorkshire Cancer Research Campaign	£3,483,000.00
Multiple Sclerosis Society	£3,442,751.00
British Diabetic Association	£2,477,000.00
Muscular Dystrophy Group	£2,225,695.00
Sir Jules Thorn Charitable Trust	£1,838,072.00
Cystic Fibrosis Research Trust	£1,500,000.00
William Harvey Research Institute	£1,434,000.00
National Asthma Campaign	£1,395,821.00
Birthright	£1,335,599.00
Tenovus Cancer Fund	£1,304,370.00
Ciba Foundation	£1,303,705.00
Marie Curie Cancer Care	£1,290,000.00
North of England Cancer Research Campaign	£1,285,389.00
Mental Health Foundation	£1,154,714.00
Wessex Medical Trust	£1,102,000.00
Parkinson's Disease Society of the United Kingdom	£1,022,966.00
Leverhulme Trust	£889,000.00
National Kidney Research Fund	£878,000.00
Brain Research Trust	£869,666.00
Lister Institute of Preventive Medicine	£770,000.00
Motor Neurone Disease Association	£751,000.00
British Lung Foundation	£736,475.00
Stroke Association	£714,000.00
British Digestive Foundation	£684,740.00
Nuffield Foundation	£600,000.00
Iris Fund for the Prevention of Blindness	£546,222.00
International Spinal Research Trust	£475,398.00
Liver Research Unit Trust	£425,222.00
Spastics Society	£353,000.00
Research into Ageing	£335,590.00
Smith and Nephew Foundation	£275,000.00
Royal National Institute for the Blind	£258,000.00
British Retinitis Pigmentosa Society	£244,242.00
Foundation for the Study of Infant Deaths	£220,460.00
Blond Mcindoe Centre for Medical Research	£156,000.00
Association for Spina Bifida and Hydrocephalus	£120,000.00
Remedi	£100,000.00
Migraine Trust	£67,370.00
Living Again	£53,000.00
National Back Pain Association	£19,726.00
	<hr/>
	£238,952,753.00
Group Count: 48 (Member Charities)	<hr/>

<i>Name</i>	<i>Expenditure Tot</i>
Scottish Hospital Endowments Research Trust	£850,000.00
Guide Dogs for the Blind Association	£750,000.00
Wishbone Trust	£500,000.00
Cancer and Leukaemia in Childhood Trust	£389,000.00
Restoration of Appearance and Function Trust	£293,329.00
Bradford's War on Cancer Campaign	£238,000.00
Hearing Research Trust	£205,400.00
Friedreich's Ataxia Group	£200,000.00
Beit Memorial Fellowships for Medical Research	£197,802.00
D E B R A: Dystrophic Epidermolysis Bullosa Research	£188,849.00
Children's Liver Disease Foundation	£180,498.00
Tuberous Sclerosis Association of Great Britain	£120,000.00
British Council for Prevention of Blindness	£118,801.00
Bardhan Research and Education Trust of Rotherham Ltd	£115,000.00
Psoriasis Association	£80,000.00
T F C Frost Charitable Trust	£80,000.00
Barnwood House Trust	£50,000.00
National Eczema Society	£42,000.00
Brain Damage Research Trust	£35,000.00
Mason Medical Research Foundation	£33,658.00
Royal Surgical Aid Society	£15,500.00
Little Foundation	£4,454.00
Breakthrough Breast Cancer	
Primary Immunodeficiency Association (Formerly H G G Society)	
	<hr/> £4,687,291.00 <hr/>
Group Count: 24 (Affiliated Charities)	
	£243,640,044.00
Report Count: 72	<hr/> <hr/>

CHART 1

Expenditure on Medical Research in the UK of Member and Affiliated Charities of the Association of Medical Research Charities 1982-1992

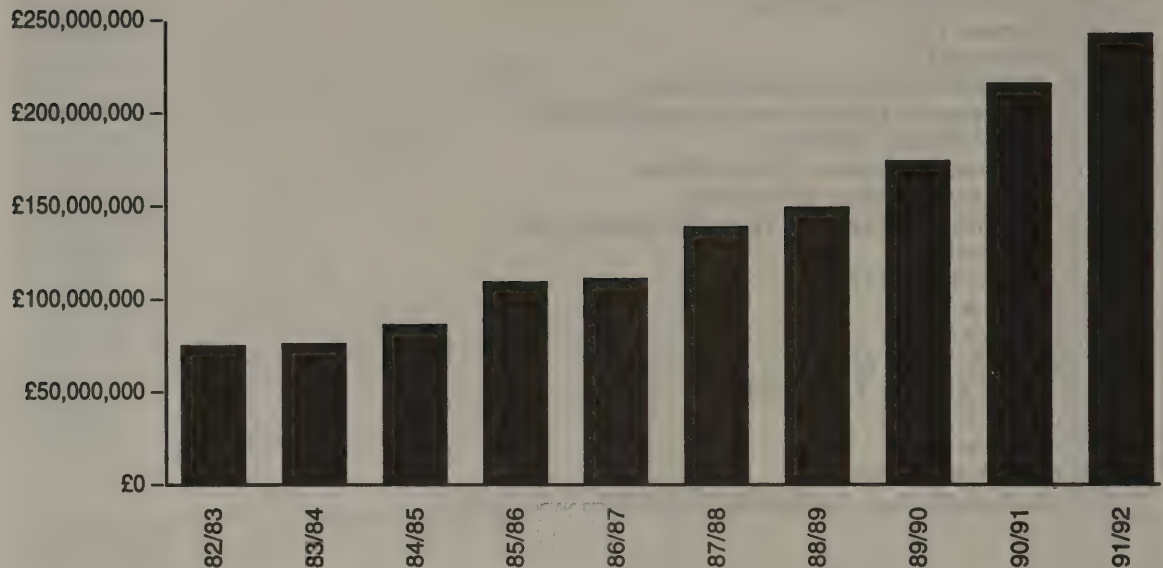
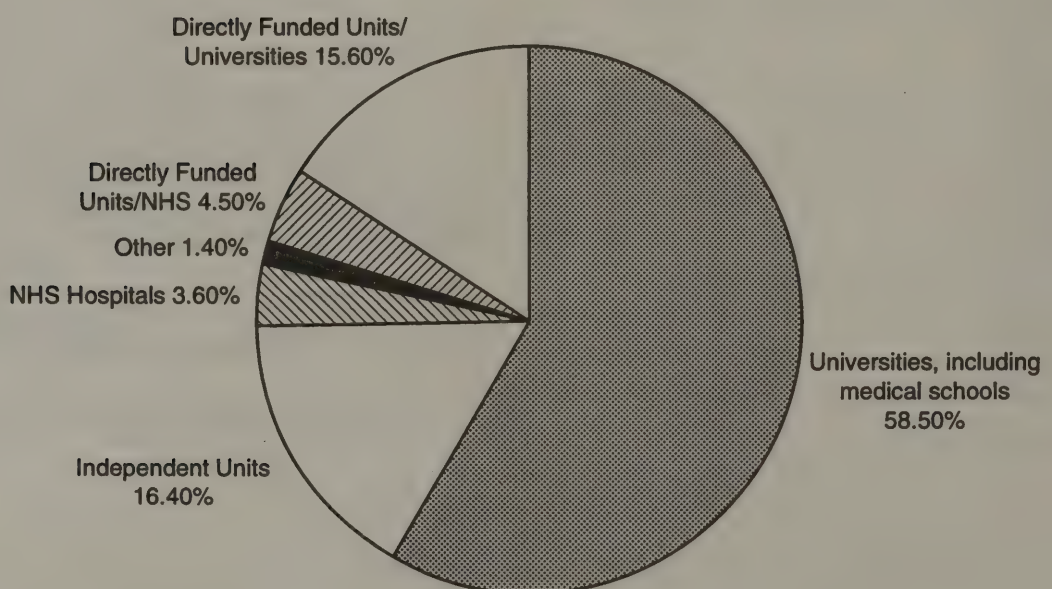
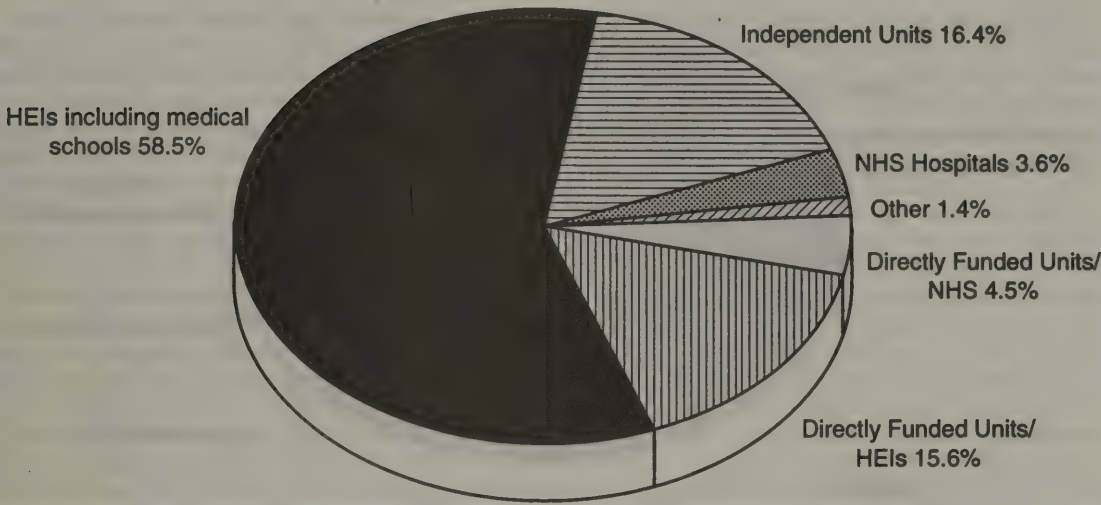


CHART 2

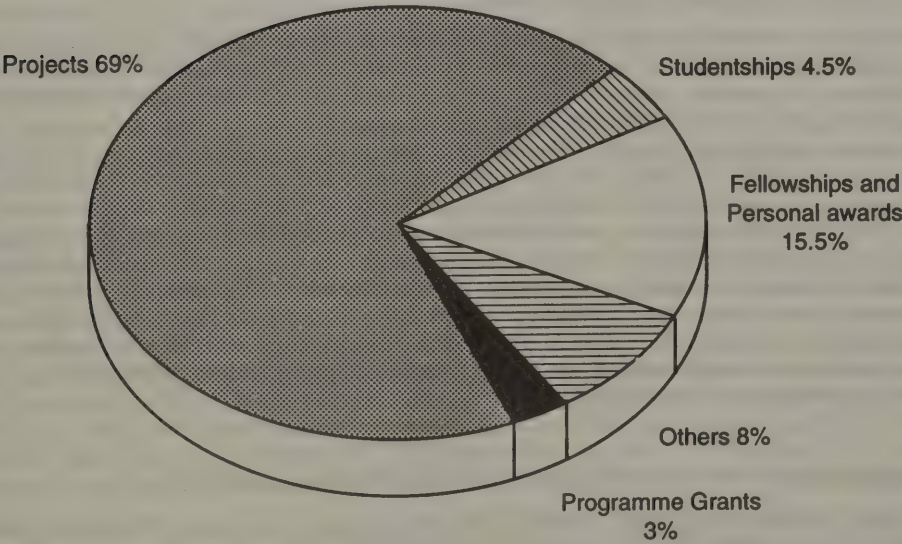
Distribution of AMRC Funding for Medical Research in the UK



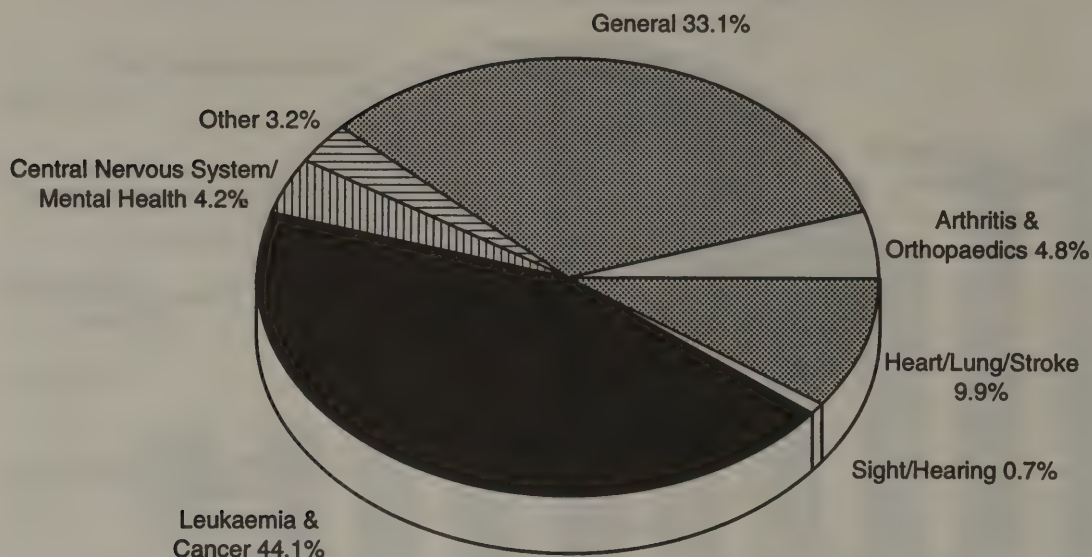
Distribution of AMRC Funding for Medical Research in the UK



Analysis of AMRC Charities Funding by Type of Grant



AMRC Charity Funding for Research - Disease Areas



Evidence from the Association of University Departments of General Practice

1. INTRODUCTION: THE ACADEMIC DEPARTMENTS OF GENERAL PRACTICE, THE AUDGP AND RESEARCH AND TEACHING IN GENERAL PRACTICE

1.1 *Academic Departments of General Practice*

Every UK university has an academic department of general practice, with professorial chairs in all but two, the majority of which are supported by HEFC funds. In addition there are three postgraduate departments of general practice which are not involved in undergraduate education. The academic departments are responsible for providing general practice-based teaching throughout the undergraduate curriculum, undertaking research in the setting of general practice and on objects relevant to general practice and supporting R&D in general practice in their regions, while contributing to the provision of NHS general medical services and academic leadership in their discipline. The academic departments of general practice are typically multi-disciplinary, with contributions to research and teaching being increasingly made by behavioural and social scientists, nurses and other health care workers, and research assistants and associates as well as academic general practitioners; the departments are sometimes part of a larger group of community-based departments within the medical school, and often have close working relationships with departments such as Public Health Medicine, Epidemiology and Health Services Research. Many departments now co-operate to draw undergraduate and postgraduate structures more closely together to provide a continuum of medical education.

1.2 *Association of University Departments of General Practice (AUDGP)*

The AUDGP was established, initially as the Association of University Teachers in General Practice, in 1974 and represents the interests and membership of the university departments of general practice and primary care in the UK. The membership of the AUDGP is currently around 350; the Association, at its scientific meeting and at regional meetings, provides an opportunity for the presentation of original research, the discussion of teaching topics and a forum for exchange and development of views. The Association is formally constituted and its chairman acts as its representative on the Conference of Academic Organisations in General Practice and is an observer on the Council of the Royal College of General Practitioners.

The Association, by gathering information about the activities of its constituent departments, reviewing developments in research and teaching and the publication of reports, has sought to ensure that these activities are appropriately recognised and funded and has for some time been closely involved in negotiations

on service support for teaching and research in general practice. It has emphasised the need to provide adequate resources to allow expansion of community-based medical education.

1.3 *Research in General Practice*

General practice research has developed enormously over the last 40 years from its beginnings as an essentially descriptive, practice-based activity to becoming a substantial academic force with a firm foundation and an extensive literature. The scope of research in general practice is wide, and includes studies on the epidemiology, causes, presentation, natural history and management of conditions commonly encountered in primary care, strategies for screening and prevention of serious chronic diseases such as hypertension, cancer and stroke, and the management of long-term conditions such as diabetes, asthma, hypertension and epilepsy. It occupies a special niche in studying conditions that seldom present to secondary care, and in establishing the natural history of these disorders and of the proportion of more serious disorders that remain sub-clinical. General practice research embraces large areas of health services research, particularly in relation to the "gatekeeper" role of general practitioners to the expensive specialist sector and to other hospital-based resources. The discipline is concerned with the configuration and functions of primary health care teams, the provision of comprehensive, continuing care to individuals and populations and a wide range of studies on the behaviour of patients and clinicians. Consultation skills, prescribing practices and the use of investigations are major research areas and are profoundly important to the NHS. The increasing shift in the balance of care from the hospital to the community has challenged general practice researchers to acquire new skills to evaluate the consequent changes in clinical practice, the integration of new technologies and the changing roles of members of the primary health care team. Primary care has a special role in defining the costs of care to patients; for example the association of bendrofluzide with impotence, and of the oral contraceptive pill with thrombo-embolism among older smoking women came from research in primary care networks.

A multi-disciplinary approach to research and development, particularly in relation to the management of chronic diseases and the estimation of the costs and benefits of new forms of primary health care delivery, is a particular strength and success. Examples include the provision of structured care in general practice for diabetes and of nurse-led care for asthma and hypertension. These alternatives to hospital-based care are frequently more attractive to patients and may consequently promote compliance, for example with dietary advice and visual surveillance in diabetes. The effective deployment of the research skills of social and behavioural scientists have laid the foundations for effective primary and secondary prevention in general practice, particularly in relation to the study of lifestyle and behavioural change in management and preventive strategies for diabetes, myocardial infarction and cancer. The increasingly robust health services research undertaken in academic departments of general practice has helped to define and emphasise the cost-effectiveness of primary care in the UK, reflected in many of the interests of the Department of Health's Technology Assessment Board, and is exemplified by initiatives such as computer-supported near-patient testing systems, "substitution" into general practice of many traditional secondary care functions, evaluation of new genetic technologies and the continuing evaluation of the shift in clinical care across the primary/secondary care interface described earlier. In general practice research the sciences of discovery meet the sciences of implementation.

Academic general practice also has a substantial record of achievement in clinical standard setting and educational research, for example in developing valid and reliable methods of assessing clinical competence.

1.4 *Teaching in General Practice*

As the clinical focus shifts from the hospital to the community, so there is a need to provide greater teaching resources for undergraduate students in community settings, mainly in general practices. Patients are spending less time in hospital, both as in-patients and out-patients; there is an increasing acceptance of recommendations, made repeatedly by the General Medical Council and supported by other organisations such as the King's Fund and the AUDGP, to provide, *inter alia*, more community-based teaching, which includes instruction and assessment in the skills of communication between clinicians and patients. The academic departments are eager to accept the challenges and expectations inherent in these recommendations, whilst recognising that resources need to follow teaching just as clinical resources follow patients.

The need to provide an adequately-resourced community-base for teaching and research is a powerful argument for the provision of substantial extra funding for the academic departments of general practice and their associated teaching and research practices.

Although general practice has recently benefited from Tasked NHS money to underpin the infrastructure of academic departments and receives an "undergraduate education allowance" within GMS fees and allowances, the first arrangement is presently being continued on a year to year basis and the second element is at a very modest level. General practice now requires a secure equivalent to SIFTR to enable the discipline to continue its attempts to build an effective career and training structure to produce the skilled academics needed to respond to the challenges of research in a changing NHS.

2. AUDGP RESPONSES TO THE SUBCOMMITTEE'S QUESTIONS ON THE NHS R&D STRATEGY, THE CULYER REPORT AND ADDITIONAL CHALLENGES OR OPPORTUNITIES FOR UK MEDICAL RESEARCH

2.1 *The NHS R&D Strategy*

The AUDGP welcomes the NHS R&D strategy and supports changes in the funding flows implicit within it. In particular the Association supports the criteria for NHS R&D need developed by the advisory groups on R&D priorities, and welcomes the emphasis on the dissemination and implementation of research findings and the optimisation of their impact and benefits on patient care. The Association does, however, have concerns that this has largely been a top-down exercise in which the problems of secondary care, and therefore of its funding, have dominated, although we recognise that the advisory groups have, within their terms of reference, conducted broadly-based consultation exercises involving a range of service providers and others. We believe that a more bottom-up approach, which is likely to have taken longer, would better develop primary care services and ensure the incorporation of patient and consumer perspectives. The Association also has concerns about the balance between central control and peripheral ownership, with obvious implications for commitment to the strategy, and is also concerned about the enormous amount of time taken in the preparation and peer review of bids for funding, particularly in the first four months of 1994.

One of the expressed aims of the NHS R&D strategy is to enhance research in and into general practice and primary care, and although the strategy has opened some doors to funding, its implementation has been patchy. This is often related to the preoccupations of individual Regional Directors of Research and Development; there are examples of excellent support and the provision of funding for research networks and research fellowships, whilst at the same time there is evidence of less interest in the promotion of primary-care based research.

In relation to the Centre for Primary Care Research and Development based in Manchester, the AUDGP welcomes any new support for research in general practice, but is concerned that the thinking behind the establishment of the centre may have been extrapolated from bio-medicine rather than from the principles of general practice. It is possible that the Centre may not yet be able to deliver all that is expected from it because of a lack of research infrastructure in the discipline. It is certainly not possible to answer all questions about primary care or to train sufficient research staff on a single site.

The Association strongly supports the establishment of the Cochrane and York Centres to promote the systematic review of research evidence, contributing to research-based practice. We have some reservations about the primary care input into these initiatives, and also about the ways in which the evidence for clinical effectiveness will be disseminated and implemented, because in primary care, contextual and personal variables are of equal weight to biomedical evidence. This broader perspective is not always grasped by those who collate and present the evidence.

In terms of taking the NHS R&D strategy forward, the Association would strongly urge the Director of NHS R&D to recognise the key role of the gatekeeper function of general practitioners in delivering a cost-effective health service, and to ensure that adequate evaluation accompanies many of the policy-driven initiatives which threaten to destabilise this system.

2.2 *The Culyer Report*

The Culyer report on supporting research and development in the NHS clearly introduces greater transparency into NHS R&D funding and the Association is in favour of this. There may, however, be dangers in opening up the true cost of research to purchasers, and we are concerned that the commercial approach may elbow out traditional professional values with further destabilisation of core structures. For example top-slicing may be an appropriate funding mechanism, but this will also include top-slicing from GP fund holders, and may cause unnecessary polarities within the general practice research community. The Association believes that one way to avoid this, and to provide the basis of a more equitable and effective academic structure, is to combine the "T" and "R" elements of SIFTR within university departments and practices identified for undertaking teaching and research.

The MRC has commented that because of the lack of provision for support of research in general practice, there is pressure on general practitioners to charge for some costs involved in undertaking research. The MRC also stated that research does not generate income in the same way as clinical activities and that there is growing evidence that GPs are consequentially less willing to participate in research. The Association agrees that there may be a problem here and that the Culyer report will help but not necessarily for the reasons set out within it. At present there is no slack in the system, and general practitioners are unable to take on new tasks. The Culyer report may enable them to do more, particularly if the "T" and "R" components of SIFTR are used within the same practices to provide an appropriate infrastructure for an academic (research and teaching) base.

2.3 Other Issues

The provision of Tasked Money, through Regional Health Authorities, has provided welcome relief support to academic departments of general practice, although the present level of funding represents only a fraction of that required to create the academic infrastructure described above. Substantial additional infrastructural funding is needed if general practice is to respond to the increasing academic demands placed upon it. Whilst there is a clear argument for the creation of a sound academic base in the university departments and their associated practices, the Association equally recognises that general practitioners must compete for research funding on the same basis as others in the NHS and universities. Whilst SIFTR could well be used in part to support much-needed training opportunities in primary care (including the establishment of research training fellowships), we recognise that primary care researchers themselves will have to compete for local and national project and programme research grant funding in open competition with others.

3. CONCLUSIONS

3.1 Research in General Practice: The Future

In a radically altered National Health Service and a rapidly changing society, the challenges of delivering effective primary care to the population are ever-increasing. At present 93 per cent of NHS contacts take place in primary care at a cost of 6 per cent of NHS expenditure. The solutions to problems such as the provision of adequate care to inner-city populations, the management of mental health problems in the community, the prevention and early identification of life-threatening disease, responses to new problems in medicine and society and to changing health care technologies demand that developments in health care are, whenever possible, evidence-based and, when determined by policy, are adequately evaluated. In a primary care-led health service, an adequate research infrastructure for general practice is essential if we are to respond to these problems and to provide answers to major questions concerning the delivery of an effective health service.

3.2 Academic General Practice: The Future

Strong university departments of general practice are essential to provide a training ground for the development of research skills to answer the research questions of primary care, and also to lead and co-ordinate community-based medical education. This work must be supported by adequately-resourced and supported academic practices, working closely with the university departments to extend the facilities available for research and teaching and to increase the critical mass of trained researchers and educationalists required.

Evidence from Professor Alasdair Breckenridge, Regionall Director of R&D, North West Regional Health Authority

INTRODUCTION

As the Regional Director of R&D (RDRD) for North West Region, and a founder member of the Central Research and Development Committee (CRDC), I am fully signed up to the NHS R&D Strategy and I have played a role in formulating and implementing its central and regional components. This Region, for example, proposed that the field of Dentistry should be added to the components of the commissioned programme. The North West Region, formed by the fusion of the former North Western and Mersey Regions, has formulated its new R&D plan, a copy of which has already been sent to the Select Committee.

My evidence to the Select Committee is given under the three headings suggested in the invitation.

1. Assessment of the NHS R&D Stratagem

1. The point has been repeatedly made that for many reasons the current NHS does not represent a friendly environment for research, and the reforms which are currently being enacted do not improve this. Reorganisation of any large community never occurs at an appropriate time for all its participants and the present changes in the NHS Regional structure and function come at an unfortunate time for R&D. The fusion of 14 Regions into eight, the disappearance of Regional Health Authorities in 1996 and the current reduction in the number of personnel in regional offices all pose problems for NHS R&D initiative which is in an early stage of development. Hitherto effective R&D networks have been made more difficult to manage by virtue of the size of the new Region. The requirement that RDRDs should become full time civil servants will result in this RDRD (and several of his colleagues in other Regions) not being able to continue in post. This Region is already experiencing difficulty in attracting persons of suitable experience and calibre to apply for the post of full time RDRD under the new regimen. On the positive side R&D has however, taken the opportunity to forge closer links with performance management, audit and other key functions in the Regional Office.

2. In this changing scene, there is still an expectation in some quarters that investment in the R&D programme will produce results in the short term but the effectiveness of the programme will largely depend on the attitude of purchasers. While many purchasers of health care pay lip service to the importance of R&D, there are still few examples of where those products of R&D which have been shown to be important have been incorporated into purchasing plans. Many purchasers who are "on board" and who appreciate the relevance of the development part of the programme, eschew its research side regarding its funding as the role of other parties. In this climate, the proposal under the Culyer Report that the funding of R&D should come in part from a levy on purchasers will have to be spelled out very clearly and its advantages stressed.

3. Two of the main aims of the creation of the NHS R&D strategy are to promote health services research (HSR) and to implement research findings in clinical practice. Without entering into discussions on the definition of HSR, this aim has been widely accepted by the research community. While biomedical research must form an important part of the NHS programme, the main thrust of this strategy should be in areas such as Health Technology Assessment, in understanding and implementing cost effectiveness, and in issues surrounding dissemination of information and implementation of the results of research into clinical practice. I believe that there is a considerable danger that the distinctive character of the NHS R&D strategy may be lost. This is not altogether the fault of the Research & Development Directorate (RDD). It always was the intention of the NHS strategy to collaborate closely with and complement the work of the Research Councils (MRC & ESRC). These councils have now espoused initiatives hitherto the preserve of the NHS. For example, the recent HSR Research initiative of the MRC has resulted in the funding of a Centre for HSR (centred on Bristol and headed up by a distinguished NHS RDRD). This makes the separate characteristics of the NHS & MRC strategy difficult to discern.

My own view is that the NHS R&D programme should have features which mark it out from those of other agencies. The old dual support system (UFC and MRC) has gone and should now be replaced by a triple support system (HEFCE, MRC & NHS) and the role of each of these constituents must be complementary. A new Concordat between the NHS and the MRC is about to be negotiated and this issue should be discussed.

2. Response to the Culyer Report

1. The author of the report, Professor Culyer, acknowledges that it is long on principle and short on detail, and he sees one of its main functions as setting the framework for future debate. Its acceptance in principle by the Secretary of State in December 1994 is to be welcomed; the implementation of its recommendations will require considerable skill and much hard work.

2. One of my concerns about the Report relates to the definition of respective roles of "the Centre" and "the Regions" in responsibility for the R&D process and this is not spelled out. Under the present system, the Regional Directorate of R&D and its advisors enjoy flexibility in pursuing funding stratagems. Each Regional Directorate has gone to some lengths to define local priorities in R&D and to provide appropriate funding. Thus the R&D plans of the previous 14 regions showed diversity in methods of working but an equalising influence was exercised by the DRD, and at the monthly meetings of RDRDs and R&D managers. It is not clear from the Culyer Report how much independence and flexibility the RDRDs will enjoy under the new proposals. It is unclear how the single funding stream will be managed and in setting up the various working parties to oversee the implementation of the Report, I would hope the RDD will ensure that regional priorities and their implementation are still possible under the new funding mechanisms. Each Region has evolved its R&D stratagem in a unique manner through debate and discussion, and a plea is made for allowing flexibility in methods of working at regional level to deal with local issues.

3. Several Regions are facing the problem of capital funding for embedded accommodation for research and education and in this Region the proposals to rationalise facilities on the Withington & Wythenshawe sites in South Manchester have raised this issue. It is proposed that Wythenshawe will be the main hospital site for both service and education but at present it has no research and teaching centre. There is however a very adequate resource for these purposes in Withington Hospital which is to be downgraded as a hospital. When Culyer describes research facilities (infrastructure) support, does he envisage that this will provide capital funding for buildings in centres of excellence?

4. The Select Committee will have been told on many occasions of the importance of long-term research support for clinical trials, a form of research where the UK has a long and distinguished history. Clinical trials are very much under threat at present because the future funding for those centres where multicentre trials are conducted is unclear. Transitional funding arrangements are in hand—for example there is a temporary arrangement between the MRC (one of the main originators of large scale clinical trials) and the NHS (which is required to provide service support under the terms of the most recent Concordat). My experience as Chairman of the MRC AIDS Therapeutic Trials Committee is that many clinical centres important for AIDS research are now so concerned about the continuing uncertainty of long-term funding that they are responding to the blandishments of the pharmaceutical industry, and entering their patients into industry trials where funding is immediate and guaranteed. An inevitable result is that recruitment to MRC sponsored trials will become more difficult since the pool of available patients is limited. The whole issue of service support for MRC sponsored clinical trials must be firmly grasped and spelled out to the research community and the NHS with urgency.

5. Culyer deals with the issue of "implicit" R&D activity such as R&D funded by NHS Trusts from their own resources. The magnitude of this form of funding is unknown, and it is proposed that this should become less opaque, should be declared and come into the general funding stream. The case for following this latter course of action has not been well made. Several Trusts have even expressed the fear that if they do declare in this manner, these resources will in some way be confiscated! If this aspect of the Report is to be pursued, there is an urgent need to explain to Trusts the advantage of declaring their spend, and detailing it under the funding headings used in the Culyer Report. It will also be essential to ensure that they are provided with effective information systems to facilitate the collection of these data.

3. *Additional challenges and opportunities*

The main challenge to UK Medical Research is the reversal of the decline of the performance of clinical research in the UK over the past 20 years, as documented by indicators such as citation indices. The attraction and excitement of basic science to the young medically qualified research worker (coupled with an apparent greater tendency for research councils to fund basic rather than clinical research) exacerbates an already difficult situation. The initiatives of the present NHS programme in training are very much to be welcomed as a contribution to help reverse the above trend by promoting HSR and this must be done as a collaborative exercise with other interested parties.

The Culyer Report does not address the issue of training at any length or the provision of career structures for NHS researchers, since it was not part of the Committee's remit, although it does recommend the development of a human resource strategy for R&D in the NHS, embracing training. This needs to be pursued as a matter of some urgency in view of the documented trends referred to above and could be the remit of one of the post-Culyer working parties.

CONCLUSIONS

The NHS R&D programme is moving ahead in an appropriate direction and with admirable vigour; those of us who are part of it are proud of its early achievements. The Culyer report is both timely and helpful, but its implementation at a time of yet further change in the NHS will have to be managed with great care both at the centre and in the regions.

Alasdair Breckenridge
Regional Director of R&D North West Region

Evidence from the British Dental Association

The BDA welcomes the opportunity to inform the Select Committee of its concerns over the potential impact which NHS Reforms may have on **Oral and Dental Research**.

UK ORAL AND DENTAL RESEARCH

The majority of UK oral and dental research is carried out within University Dental Schools attached to Dental Hospitals. Unlike District General Hospitals linked with Medical Schools, Dental Teaching Hospitals, as institutions, exist primarily to support the education and training of undergraduate and postgraduate dental students. The nature and extent of this teaching function is reflected in the funding of Dental Hospitals which derive, on average nationally, a notional 85 per cent of their income from SIFTR (Service Increment for Teaching & Research). It is important to appreciate that the research (R) component of SIFTR is a relatively recent inclusion in the formula; its introduction was not accompanied by extra resource nor has this element been quantified objectively for dentistry. Any attempt to do this or to withdraw it (see later comments on Culyer report) must take account of the fundamental differences between Dental and Medical SIFTR.

The majority of staff conducting research in Dental Teaching Hospitals are University employees with Honorary NHS contracts. As such, these clinical dental academic staff are under a contractual obligation to engage in research, in addition to meeting their teaching and NHS service commitments. The current emphasis within the University system on research output and the acquisition of research funding from non-University sources (eg, the NHS, research councils, charitable bodies, industry and commerce etc), form the basis for assessment in the HEFCs' (Higher Education Funding Councils) "Research Selectivity/Assessment Exercises"; ratings awarded via these assessments are used in the formula which determines the level of support for individual Universities with Dental Schools.

Estimates of the current level of funding, from a variety of sources, for oral and dental research in the UK yield a figure of about £1.8 million per annum. By contrast, the expenditure attributable to NHS dentistry in

the General Dental Services alone amounts to some £1,600 million per annum; this figure takes no account of NHS expenditure on either the Community or Hospital Dental Services including Dental Teaching Hospitals. Even as a proportion of the NHS spend on the General Dental Services, the sum currently committed to oral and dental research from various sources (1,600: 1.8) is derisory and compares very unfavourably with the 1.5 per cent of total NHS expenditure proposed for R&D within the NHS as a whole.

Notwithstanding chronic underfunding, oral and dental research in the UK has enjoyed a well-deserved reputation, both nationally and overseas, for innovation and quality. However, output has been falling, a feature which reflects the regrettable, but hopefully reversible, decline in the status of UK science generally consequent upon reduced R&D expenditure all round. Remedial action for dentistry requires a better appreciation, derived from improved representation at all levels of the decision making process, of the problems confronting dental research workers.

Constraints on the research productivity of clinical dental academics have not received sufficient recognition and are as follows:

- (i) Clinical teaching of undergraduate dental students requires frequent and close supervision by staff, a factor recognised by the HEFC in the funding formula it applies to Clinical Dentistry; this acknowledges an 80:20 split between teaching and research. The comparable ratio for Clinical Medicine is a 65:35 split between teaching and research. Accordingly, clinical dental academic staff have significantly less time available for research than their medical counterparts, both groups being markedly constrained by comparison with non-clinical academic staff.
- (ii) A further constraint on the effective time available for research by the clinical dental academic is represented by the relatively smaller numbers of NHS clinical staff, available to fulfil the NHS service commitment, employed in Dental as compared to Medical Teaching Hospitals. The increased emphasis, in some cases contractual, being placed on NHS staff to engage in research could further increase the pressure on clinical academic staff to use even more of their limited research time to fulfil service commitments.
- (iii) Realistic access to funding in support of research, outside that available from the Research Councils, is effectively restricted for the clinical dental academic. With very few exceptions, oral disorders and diseases are not life-threatening and their study does not generate emotive support, in the context of research funding, in the way that topics like breast cancer, diabetes, arthritis and childhood leukaemia do.

Depending on how the Culyer proposals are implemented in relation to Dental SIFTR, the constraints on Dental Research could well be exacerbated.

THE NHS R&D STRATEGY:

We welcome the attempts to rationalise and prioritise research and development within the NHS. In this context, we were pleased to participate in the Advisory Group reporting to the Central Research & Development Committee on R&D Priorities in relation to Primary Dental Care.

However, given that the overall NHS R&D Strategy is largely focused towards achieving targets identified in the "Health of the Nation", it is a matter of continuing regret to us that all reference to Oral Health was omitted from this key policy document. The Department of Health preferred to develop a separate "Oral Health Strategy for England" which was published in July 1994, some two years after the "Health of the Nation". In view of this delay, we believe it is essential that all levels throughout the NHS R&D Directorate are made aware of the existence of the "Oral Health Strategy for England" and are encouraged to view the achievement of its targets as being no less deserving of research and its funding than those in the "Health of the Nation".

In this context, we would hope that the report to the CRDC of the Advisory Group on R&D Priorities in relation to Primary Dental Care, which complements and reinforces objectives set out in the "Oral Health Strategy for England", is taken forward with the commissioning of research projects; we consider it essential that the commissioning phase, including the process of peer-review, is supported by adequate dental input and that this should be actively sought by all levels of the R&D Directorate, especially Regionally.

THE CULYER REPORT

We accept the need for accountability and recognise that this theme underpins many of the recommendations in the report. However, we are very concerned that the "broad-brush" approach adopted may, unwittingly, have put the future viability of dental research at considerable risk.

There are fundamental differences between Dental and Medical SIFTR. However, the Culyer report makes no such distinction; indeed, it is not clear whether the SIFTR referred to throughout the report is intended to comprise all SIFTR (ie, both medical and dental) or just Medical SIFTR.

If all SIFTR is at risk, the proposal to withdraw the research (R) component to a central pool which would be re-allocated on the basis of research selectivity/assessment could have profound implications for Dental Teaching Hospitals in general and Dental Research in particular.

In this context, we are concerned that a recent Department of Health circular to Regions used a figure of 25 per cent as the (R) component of SIFTR which was to be withdrawn for re-allocation; as in the Culyer report, this document made no distinction between Dental and Medical SIFTR. However, it is clear to us that the 25 per cent (R) factor can only relate to Medical SIFTR; there is as yet no agreed comparable figure for Dental SIFTR but recent speculation centres around a figure of 5 per cent for the (R) factor. There is evidently an urgent need for clarification as to the Department's intentions in respect of Dental SIFTR.

If the (R) factor in Dental SIFTR is to be withdrawn for re-allocation, will the resource be concentrated in a Dental SIFTR pool (ie, ring-fenced) available only for redistribution to Dental Teaching Hospitals according to research ratings? The Culyer report gives no guidance in this respect but it is clear to us that a decision to withdraw all Dental SIFTR to a central SIFTR pool with no assurance that it would be protected for research-rated re-allocation among Dental Teaching Hospitals would seriously jeopardise their viability.

Furthermore, suggestions that re-allocation of the (R) component might be based on ratings from the HEFCs' Research Selectivity Exercise are unacceptable since such an approach ignores the essentially different nature and functions of clinical (NHS) as distinct from academic (University) research.

What would happen if a Dental Teaching Hospital lost the (R) component from its SIFTR allocation? Given that in such a situation there would remain a continuing need to meet both the Purchaser's service contract and the General Dental Council's statutory recommendations concerning the undergraduate curriculum, it seems likely that the net effect would be, inevitably, a significant deterioration in Dental Research activity and productivity.

Inevitably, much of this submission has concentrated on the potential impact which NHS Reforms may have on Dental Teaching Hospitals, given that the majority of oral and dental research is carried out in these institutions. However, it is important to recognise that an increasing volume of applied dental research is being generated from within the Community Dental Service and General Dental Practice; in this respect, we welcome the proposal in the Culyer report that funds from the NHS R&D budget should be available to all parts of the NHS undertaking high quality research, including primary care and community health services.

CONCLUSIONS

1. Dental Research is largely conducted by clinical academic staff employed within University Dental Schools that are inextricably linked with Dental Teaching Hospitals.
2. For reasons that are not fully appreciated outside dentistry, past levels of dental research activity have been constrained by both funding and staffing considerations.
3. Dental Teaching Hospitals receive the majority of their funding, 85 per cent on average, via the SIFTR mechanism.
4. There are fundamental differences between dental and medical SIFTR and it is essential these are recognised throughout all levels of the NHS R&D Directorate.
5. The recently published "Oral Health Strategy for England" should act as one of the focal points for future dental research activity supported by NHS funding. We believe that all levels of the NHS R&D Directorate should give this document equivalent status to the "Health of the Nation" when developing policy for NHS-funded research.
6. The proposal in the Culyer report to remove and re-allocate the (R) resource element from SIFTR could have profound implications for dental research and Dental Teaching Hospitals if applied to Dental SIFTR without very careful consideration.
7. Past experience, and the Culyer report is yet a further example, shows that strategic policy initiatives leading to major NHS reforms are often developed without sufficient, or sometimes any, consideration of their impact on Dentistry.

Evidence from the Central Manchester Health Care NHS Trust

SUMMARY

The Central Manchester Health Care NHS Trust (CMHT) strongly supports an NHS research strategy which contributes to the development of effective health care.

We do not repeat at length the arguments presented by the Council of Deans of UK medical schools, whose evidence the CMHT strongly supports.

We concentrate on the proactive measures that this Trust is undertaking to guarantee high quality R & D relevant to the needs of the NHS.

We are developing a robust system to facilitate a strategy for:

- rigorous evaluation of existing and proposed research,
- achieving a balance between disinvestment and reinvestment,
- promoting a more knowledge based healthcare system,
- using R & D to evaluate natural clinical groupings.

Regional and national directors of R & D should encourage such systems generally within the NHS.

CONTENTS

1. General
2. Research quality and need for evaluation
3. Case study
4. CMHT research quality programme
5. R & D led evaluation of all clinical services
6. Comments on Culyer

1. GENERAL

1.1 The Central Manchester Health Care NHS Trust (CMHT) strongly supports an NHS research strategy which contributes to the development of effective health. We believe that this is putting the UK at the forefront of development strategy in the world and promises to make major contributions to effectiveness and cost-effectiveness of health care in this country.

1.2 Health services research has previously been undervalued and underfunded and now needs secure and adequate funding to encourage good quality testing strategies for “optimising what can be achieved in practice from what is already known”.

1.3 For this to be effective the CMHT also strongly supports a “balanced portfolio” of R & D including original biomedical and clinical research, development and evaluation culminating in health services research.

1.4 This portfolio must include multidisciplinary research, including medical doctors, clinical scientists, dentists, nurses and other professions allied to medicine, and studies in primary care settings.

1.5 There is some danger of basic research in biological and other sciences being seen as “at odds” with clinical and health services research. This would be unfortunate given the extraordinary speed with which new biological advances are being put into clinical practice.

1.6 There needs to be a clearly defined relationship between NHS, University and research councils.

1.7 It is important to note that funds allocated by Purchasers for NHS service delivery will not be applied to R & D.

1.8 Research planning is best done in partnership with the University when R & D appropriate to the role of the institution can be concentrated.

1.9 Biomedical research, whether funded by the NHS, research councils, charities or the pharmacological industry is a key part of the functioning of teaching hospitals because:

1.9.1 biomedical and health services research are complementary to each other.

1.9.2 biomedical research is the substrate on which future improvements in prevention, diagnosis, and treatments are based, important considerations given the lack of effective prophylaxis or treatment for many disorders.

1.9.3 the juxtaposition of original research and resulting service, facilitates both the rapid development and evaluation of new diagnosis and treatment and helps basic scientists to be conscious of the research opportunities provided by human disease.

1.9.4. the access to the NHS test-bed—qualified support staff, space and equipment, and access to patients

1.9.5. such research motivates many consultants, NHS scientists and junior doctors.

2. RESEARCH QUALITY AND THE NEED FOR EVALUATION

2.1. The quality of research is paramount, and poor research has to be weeded out and resources released for new, and more relevant high quality research.

2.2. Consequently the CMHT has strongly endorsed the need for rigorous review of all NHS supported research, including that funded from outside sources but performed on NHS premises.

2.3. CMHT recognises that this may have consequences for career development of junior doctors.

2.4. There appears to be a greater coherence of the national programme than of regional programmes and we perceive a lack of confidence at the moment in regionally based R&D programmes. This has been particularly obvious within our own region where Mersey and North Western Regions took very different approaches to R&D. Perhaps some of this is inevitable, partly because of the differences in perception of local needs, partly because of the limitation of resources which can be put into the development of regional R&D strategy.

2.5. Because there was no evaluation of existing research programmes, the dramatic changes have had unfortunate effects on the bed-rock of research infrastructure and careers of staff in which the NHS has invested over many years. The following case study illustrates the dangers of rapid unevaluated change and has important implications for the implementation of the Culyer report.

3. CASE STUDY

3.1. The North Western Regional Health Authority for nearly 20 years had funded a research infrastructure programme with an annual budget of £1½ million. Before the announcement of the NHS R&D initiative, the research advisory committee had initiated a rigorous review which quickly released considerable resources for reinvestment in health services and other research. This progressive shift towards health services research was superseded by the abolition of the scheme without review. This has threatened redundancy to many researchers without any attempt to assess their merit and has had the effect of creating an atmosphere of gloom, pessimism and cynicism about the NHS R&D initiative.

4. CMHT RESEARCH QUALITY PROGRAMME

4.1. Faced with this confusion the CMHT embarked upon a global evaluation of all its NHS supported research, beginning with the 19 regional research infrastructure programmes held in the Trust (representing the loss of a total budget of £500,000). These were subjected to detailed scrutiny including assessment of research quality (judged by publications, grant records and external peer review) and relevance to the NHS. It was discovered that regionally funded infrastructure had been the springboard for the success of a number of very high quality research endeavours including MRC programme and "special project" grants and a Department of Health molecular genetics Special Medical Development which has become a national model.

4.2. We therefore welcome the recommendations of the Culyer report on the costs of maintaining research facilities and staff (see 6.6 below).

4.3. The CMHT is working to develop its own R&D strategy to take advantage of the opportunities offered by Culyer.

4.4. The CMHT has a well advanced quasi-HEFC research assessment strategy but one which gives appropriate weight to both NHS relevance and to international/national academic excellence. To date more than 200 active researchers have been registered as a basis for the development of an integrated R&D community linked by electronic noticeboard.

4.5. The CMHT held an R&D exhibition on 30 September 1994 for which 240 application abstracts were received from which 60 posters were selected. These were judged by a distinguished external panel which awarded five prizes, including one for the best multidisciplinary research.

4.6. A second, this time national exhibition is planned for summer 1995 at which the emphasis will be upon actual examples of original research which has led within the CMHT to evaluated services now included in contracts with purchasers.

5. R&D LED EVALUATION OF ALL CLINICAL SERVICES IN CMHT

5.1. R&D has been recognised as central to the CMH Trust's future general success.

5.2. R&D is currently leading a pilot "5 point evaluation" which if successful will be applied to every natural clinical grouping (NCG).

5.3. The 5 points of the evaluation coincide with work of well established committees and comprise (1) audit record, (2) teaching, (3) research and development, (4) clinical and contract performance and (5) special considerations (eg, one NCG is currently providing the Dean of Medicine and several have innovative developments not yet in contracts).

6. COMMENTS ON THE CULYER REPORT

6.1. The NHS needs carefully to consider the effects on teaching hospitals of the shift in R&D income initiated by the Culyer report and put in place *robust* transitional arrangements.

6.2. CMHT therefore welcomes co-operation among purchasers, providers and researchers to help overcome the cultural differences among these three groups. It is only by overcoming such differences that the research needs of the NHS can be met.

6.3. The Culyer committee recognises the threat to clinical research posed by the purchaser/provider split, in particular:

6.3.1. Cost pressures forcing health care providers and purchasers to take a short-term view and making them less inclined to invest in R&D.

6.3.2. Purchasers being reluctant to pay for the service costs of procedures under evaluation, especially the higher costs to purchasers close to research active hospitals.

6.3.3. The increasing tendency not to fund tertiary referrals on which much R&D depends and to support local providers rather than sending patients to major research centres, so putting independent evaluation at risk.

6.3.4. The potential erosion of the clinical research base as a result of diversion of resources towards health services research.

6.4 We believe that the Culyer report goes a long way towards addressing these issues particularly by the suggestion of a levy of all purchasers to be used for R&D.

6.5 The recognition that service support is needed for research in primary and community care is also welcomed.

6.6 Because of our experience of establishing the value of the spring-board effects of some of our regional research infrastructure programmes (see 4.2. above) we particularly welcome that the Culyer report recommended:

“costs of maintaining particular research facilities and staff which enable R&D projects and programmes to take place, but which are not reasonably attributable to a specific programme or project”.

6.7. In terms of opportunities for medical research which are not currently addressed by the NHS R&D strategy or by Culyer, we think there are a number of points:

6.7.1. There is a clear tension between “science push and needs pull”. There is a danger that the emphasis has shifted too much from the former to the latter. The NHS programme at least locally in the North West does not seem to be in a position to take a long-term view of research. It focuses excessively on the historical lack of applied research rather than taking a balanced approach to the full range of research required.

6.7.2. There is a very great need for an integrated approach to basic biological research and health services research, and this is not all that evident in the NHS R&D strategy. This contrasts with the MRC which puts quite a lot of effort into trying to integrate these two poles of medical research. We are not quite sure what the role of the NHS programme should be in this respect, but it certainly is not an interface which can be forgotten and is one which we shall be addressing in the development of our own Trust strategy.

6.7.3 Improving understanding of research and use of research results within purchaser and provider communities requires a major cultural change, including widespread acquisition of critical appraisal skills. It is not clear that these have been adequately developed within the programme.

6.8. Much motivation for research is curiosity-driven, and motivation for development is locally perceived needs for improvements. It is therefore essential that central planning of R&D strategies and investment are adequately responsive to local needs.

6.9. The use of the “R” of SIFTR for research projects as part of the single stream of R&D funding will require providers to protect services when disentangling “R” from general services funds (as is intended).

6.10. The mechanism to assess R&D performance proposed by Culyer must:

6.10.1. Be relatively simple.

6.10.2. Use so far as possible the same information as collected by HEFCE.

6.10.3. Avoid tensions between NHS and universities.

6.11. There should be a reasonably equitable geographical spread of R&D funding.

6.12. The main focus of development and dissemination within the NHS R&D programme has been the establishment of the Cochrane Centre and the Reviews and Dissemination Centre in York. Bearing in mind

the limited effect of written information in producing behavioural change, it may be that additional input will be needed to implement change within the Health Service in addition to the rather academic approaches being taken by the Oxford and York Centres.

Professor Rodney Harris (Chairman CMHT R&D Committee)
Dr C M Cheshire (Medical Director)

Evidence from the Council of Deans of Dental Schools

Further to the meeting between the House of Lords Select Committee and representatives from the Council of Deans of Dental Schools, I am providing information regarding the funding from the HEFCE and that received from grants. This has been calculated to discount monies that have been received from SIFTR and therefore the total should be 100 per cent that each School receives. The calculations I have received from the Schools are as follows:

School	HEFCE	Soft Money
Belfast	To be advised	
Birmingham	89%	11%
Bristol	75%	25%
Dundee	90%	10%
Eastman Dental Institute	44%	56%
Edinburgh	Not applicable	
Glasgow	75%	17% (+ 8% NHS supported salaries)
Guy's	To be advised	
King's College London	To be advised	
Leeds	To be advised	
Liverpool	To be advised	
The London Hospital	70%	30%
Manchester	77%	23%
Newcastle upon Tyne	86%	14%
Sheffield	82%	18%
Wales (Cardiff)	92%	8%

I trust that this information meets your requirements. Please do not hesitate to contact me if you require further clarification.

Professor W R E Laird
Chairman

29 March 1995

Evidence from the Council of Science and Technology Institutes, Health Care Scientific Advisory Committee

The CSTI Health Care Scientific Advisory Committee (HCSAC) was established by CSTI in 1981 at the request of the then Secretary of State for Health and Social Security, the Rt Hon Patrick Walker MP, to provide him and his Department with advice on matters relating to the application of science and scientific developments to improve the quality of Health Care. The committee membership consists of representatives of the Institute of Physics, the Institute of Biology, the Royal Society of Chemistry, the Institute of Physical Sciences in Medicine and the Association of Clinical Biochemists, all of whom have members who are employed as Clinical Scientists within the NHS.

Clinical Scientists, whose basic training is in science not medicine, form a small cohort of staff within the NHS covering a wide range of scientific disciplines, as is shown in Table 1. Their role is to apply their expert scientific knowledge to the provision of vital science based services for the diagnosis, treatment and management of patients. This role is discharged through, inter alia, R&D activity that is crucial to (a) the maintenance of high quality scientific services and (b) the development of ideas that arise from a critical review of the service provided. The first is referred to as *implicit research*, the second as *service development research*. Frequently, improved tests, better treatment methods and new medical devices or equipment arise from this research. The continued integration and support of the two activities is essential to the continued improvement of services provided by the NHS.

This critical approach to the provision and development of routine clinical services has proved to be a fertile area for innovation. Many of the diagnostic reagents and items of equipment now manufactured by the UK Medical Equipment and Diagnostics Industries as well as overseas companies arose not from explicitly funded research programmes but from clinicians and scientists working together in the NHS, having ideas, and giving time and thought to ways of improving the service provided to the patient. The continued existence

of a culture that fosters implicit research, as defined above, and funding for service development research is now under severe threat from the combined effects of the NHS Reforms; it is not helped by the recommendations of the Culyer Report, and is omitted from the NHS R&D Strategy.

1. THE EFFECT OF THE NHS REFORMS

(a) *Efficiency Measures*

Repeated Government demands, year on year, for efficiency savings, cost-improvement programmes and income generation schemes have left all staff with progressively less time to devote to improving the quality of the service provided. In the case of Medical Physics and Clinical Engineering recent studies indicate that the time available for implicit and service development research in this discipline which was estimated at 10 to 40 per cent in 1991 (POST ref 1.), had shrunk to five per cent by the end of 1993 (Sikoryn T ref 2.) and almost to zero by mid 1994 (Clifton J S ref 3). Similar experience has also been noted in the pathology services.

(b) *The Internal Market*

The distribution of Clinical Scientists is not uniform throughout the NHS. Consequently those Providers who do employ them face the difficult problem of building into their pricing structure the element of service development cost which they represent. In our experience the financial constraints on Providers to reduce costs and the overwhelming tendency of Purchasers to accept only the lowest priced tender has resulted in such a reduction of resources that many clinical science departments have had their capability to sustain implicit and service development research drastically curtailed and in some cases eliminated altogether.

(c) *Management Arrangements*

The Internal Market has engendered competition amongst Trusts and consequently individual scientific services where previously there had been co-operation and collaboration to obtain maximum benefit from the limited resources available. Further, at Trust level, there is a requirement to implement a management structure in the form of Clinical Directorates.

In many Trusts this has led to pressure to break up existing groups of physical scientists, with scientists being relocated in ones and twos to Clinical Directorates. This creates a situation analogous to that of Clinical Scientists working in isolation in a single Trust, in a sub-specialty within pathology where there are only small numbers nationwide. The policy of sequestering individual scientists into competing units destroys the critical mass of scientific staff which is universally recognised as essential for lateral thinking in R&D, and in this instance for the application in medicine of discoveries in other fields. It also removes an integrated resource of scientific expertise previously widely available to all clinical colleagues.

2. THE NHS R&D STRATEGY

(a) *Balancing Research Priorities*

The CSTI HCSAC supports the concept of a centrally commissioned R&D programme targeted at matters of specific concern to the NHS. However, the HCSAC shares the view of many academic organisations and other professional bodies that the balance of research within the R&D Strategy has swung too far towards "operational research" and "value for money". Such short-term research has an important role, but it should not be pursued at the cost of disruption to vital long-term original research projects. Innovation requires time and cannot always be guaranteed to produce results within the timetable of a tightly controlled programme. It is important that the NHS R&D Strategy does not become dominated by concerns of the moment, to the exclusion of longer-range opportunities.

The NHS R&D Strategy concentrates almost exclusively on academic research and the effective transfer of its findings into practice. The importance of implicit and service development research (which is carried out in situ) and the need to fund and support it is effectively ignored. If these deficiencies are not recognised and corrected the effect on NHS service research—and particularly on medical technology research—performed by clinical scientists employed by the NHS will be very damaging.

(b) *Health Technology Assessment*

The HCSAC is concerned at the misuse in the NHS R&D Strategy of the term Health Technology Assessment. The term has been used to describe studies into any facet of health care delivery—most of it having nothing to do with technology as defined by the dictionary or the DTI. This misuse creates the false

impression that medical technology research carried out by clinical scientists is embraced by the Strategy. The misuse of the term will also result in an over-estimate of the claimed spending on genuine technology development in the NHS, technology which could be transferred to UK Industry to create wealth.

(c) *Input to the R&D Strategy*

National Direction. A centrally commissioned programme must rely heavily on receiving the best possible advice from both experts and users. To be effective, communication networks must be established which ensure that all relevant bodies are able to input advice and ideas within realistic time scales. To date there has been a notable failure on the part of the DH to seek input to the R&D Strategy from Clinical Scientists. Refinement of national networks should be seen as an ongoing objective of the R&D Directorate.

Regional Direction. The devolution of the implementation phase of much of the R&D Strategy to Regional level is to be welcomed, but it carries with it significant risks. Devolution to Regional level will mean a requirement for local networks to complement the national advice network. It will be important for Regional Directors of R&D to establish such networks and ensure that Clinical Scientists are represented on Regional Research Committees. It will also be important to ensure that the activities of these Committees are published and subjected to strict audit in order to ensure equity and efficiency throughout the country. The organisation of R&D within Scotland, Wales and Northern Ireland should be subject to the same audit process.

3. THE CULYER REPORT

CSTI HCSAC has formulated a response to the Culyer report which has been submitted to Professor Peckham, Director of NHS R&D. A copy of that response is attached as Appendix 1.

(4) ADDITIONAL CHALLENGES AND OPPORTUNITIES FOR UK MEDICAL RESEARCH

(a) *Implicit Research and Service Development Research*

Both these functions are vital to the maintenance of the quality and the continued development of the service provided to the patient. They constitute a major responsibility for Clinical Scientists.

Culyer acknowledges the importance of implicit research but makes no recommendations that will ensure its continuation.

The furthering of ideas arising from Service Development Research (Implicit Research as defined by Culyer) require the establishment of a funding stream, similar to that recommended by Culyer for academic research, to protect the activity from the adverse effects of the Internal Market and ensure that the valuable benefits are not lost.

(b) *Improving Technology Transfer*

Curiosity-driven research, as carried out by Clinical Scientists, is a fertile ground for the cultivation of new technical solutions to medical problems. Subsequent technology transfer is an effective means of propagating the benefits of these solutions throughout the NHS and beyond, and hence of implementing the findings of research. Unfortunately there is a long history in the UK of innovative science arising from the NHS (and associated research units) being lost to overseas companies. This produces a double penalty for the UK through loss of wealth generation and the need to pay a higher price for the product when it is subsequently re-imported.

In the NHS R&D Strategy and the Culyer Report UK Industry is referred to as a potential source of funding and collaboration for the development of NHS and Academic Clinical Research. However, this is a role which can only be performed by large companies, which in the UK means the Pharmaceutical Industry. The UK Medical Devices Industry on the other hand embraces some 700 companies a large number of whom are small companies, employing less than 50 people, whose products arose from research within the NHS. The continued existence of much of this Industry will depend on new technology emerging from implicit and service development research in the NHS.

The DH should assume responsibility as the Lead Department to promote technology transfer of the results of NHS R&D to the UK Medical Devices and Diagnostic Industries and should develop an NHS Technology Transfer Strategy for this purpose.

(c) *Management of Innovation*

Implicit and service development research leads to innovations which improve the quality of the service to the patient. Culyer specifically excludes service development and it does not appear elsewhere in the NHS

R&D Strategy. Every hospital and every NHS laboratory must be able to review current practice and recent developments in knowledge and technology in order to incorporate these developments into a rational plan to improve the service. This constant review and implementation of technological innovation requires the presence of individuals trained in science and scientific methods. Omitting service development from the R&D strategy increases the risk that NHS Managers who do not understand the need to promote and manage innovation will seek short-term savings by dispensing with the services of Clinical Scientists and as a consequence a valuable resource will be lost.

An imaginative move which is urgently required is a DH-led strategy to enable NHS managers to understand, and to assist them to promote, the management of innovation.

Table 1

Specialties in which Clinical Scientists work in the NHS
Numbers employed in 1993–94

604—Clinical Biochemistry,	includes specialised biochemical services, eg paediatric endocrinology and inborn errors of metabolism; toxicology; trace metal biochemistry; genetic enzymology.
871—Medical Physics and Clinical Engineering,	includes rehabilitation engineering.
271—Clinical Cytogenetics	
71—Molecular Genetics	
99—Medical Microbiology,	includes specialised services in virology, parasitology and other branches.
101—Audiological Science	
38—Histocompatibility and immunogenetics (tissue typing)	
79—Clinical Immunology	
*** 50—Blood Transfusion and specialised haemostasis services	

Data provided by Dr P Greenaway, Chief Scientific Officer, Department of Health.

***Number estimated by CSTI HCSAC.

APPENDIX 1

Comments on the Culyer Report on Supporting Research and Development in the NHS

GENERAL

The CSTI Health Care Scientific Advisory Committee (HCSAC) generally welcomes the Culyer Report. In particular the HCSAC welcomes the Report's proposals to disentangle the funding of research and teaching and its recognition of the important role of Clinical Scientists in NHS R&D.

Specifically the CSTI HCSAC supports

- the creation of a National Forum (3.6)
- making the CRDC more representative (3.13)
- the role proposed for the Regional Officers of the NHS Executive (3.24)
- the publication of principles and criteria for funding NHS R&D (3.25)
- the introduction of a single explicit funding stream based on a levy on all health care Purchasers (3.28) (3.30)
- the breakdown of funding for NHS R&D into three categories (3.46)
- the adoption of formalised assessment and a research ratings scheme (3.57)
- the concept of R&D commissioning units (3.77)
- the national R&D database (3.91)

COMMENTS ON THE RECOMMENDATIONS

Recommendation 5

The CSTI HCSAC welcomes the concept of the formation of a broadly based National Forum to exchange information on research strategies and would be pleased to nominate a suitably qualified and very experienced Clinical Scientist to serve on the Forum.

Recommendation 6

The strengthening and widening of the membership of the CRDC is supported. The member organisations of the Council of Science and Technology Institutes represent a majority of Clinical Scientists and the CSTI HCSAC would be willing to nominate suitable candidates to serve on the expanded CRDC and Standing Groups or Sub-Committees of the CRDC.

Recommendation 7

The widening of the Concordat principle to include other funding bodies is supported but there is concern that the report does not acknowledge that the principle of the Concordat has been beneficial for Health Service R&D (the arrangement is looked on with envy from outside the UK) and that these benefits must not be lost in attempting to create a "level playing field" covering all funding bodies.

Recommendation 8

The establishment of the RDRD's office as the focal point of R&D in a Region is welcomed but it should extend to monitoring of "implicit" R&D (See also the comment on recommendation 14 below). The RDRD Consultative body should also include representation for Clinical Scientists. CSTI HCSAC would be willing to assist by nominating suitably qualified and experienced scientists to serve on these Regional Consultative Bodies.

Recommendation 12

The concept of the single funding stream is welcomed but the supporting levy must be set nationally at an adequate level. If Purchasers have discretion over R&D funding they will create a pressure to set the levy at a level demanded by those Purchasers which have the greatest fiscal problems and thus drive it down. The levy and its distribution must be put in place before Recommendation 13 is fully implemented.

Recommendation 13

The requirement for Providers to declare the direct, indirect and service costs of supporting NHS R&D is accepted, however there is concern that Providers may be tempted to over declare R&D in order to remove costs from services. It is therefore important that R&D declarations are not accepted as any form of efficiency saving.

Recommendation 14

To recommend that Purchasers "permit" Providers to undertake pre-protocol work is unacceptable. The financial constraints on both Purchasers and Providers make such permission unlikely. Purchasers and Providers may also be tempted to take the view that all R&D has been declared (under recommendation 13). There is therefore a need to give clear advice and encouragement to both Purchasers and Providers to continue to support pre-protocol/curiosity driven R&D (See further comments under Areas of Concern).

Recommendation 16

The proposal to assess groups or centres for research facility support costs is supported. It is recommended that the review is co-ordinated with (or preferably made part of) that of the HEFCE to minimise additional work.

Recommendation 23

The human resource strategy is supported strongly provided it does not overlook the needs of Clinical Scientists. Although the report recognises that career Clinical Scientists are trained in research this should not be understood as implying that their needs in this area are zero.

COMMENTS ON SPECIFIC AREAS OF CONCERN

The specific comments which follow concern areas in which the CSTI HCSAC feel that the Report's recommendations pose problems without making specific or satisfactory proposals for their solution.

IMPLICIT OR SERVICE DEVELOPMENT RESEARCH

The CSTI HCSAC endorses the concerns expressed in paragraphs 2.24 and 2.25 and recognises that paragraphs (3.34–3.41) attempt to address these concerns. However the recommendations in paragraphs 3.38 and 3.39 lack clarity and are not sufficiently strong to convince Purchasers of the value and therefore the need to support implicit research. Similarly the question of implementing new service developments (3.118) is not adequately dealt with in the Report.

The CSTI HCSAC report entitled Service Development Research in the NHS, produced at the request of the Rt Hon Tom Sackville MP, in November 1993 addressed these issues. The Committee will now produce an updated report which takes into account the recommendations of the Culyer report and suggests possible solutions to these outstanding problems.

PEER REVIEW

The concept of peer review (3.86) is welcomed. However the suggestion in (3.87) that this mechanism could be bypassed for "primary and community care" projects is totally contradictory to statements throughout the report about ensuring that only "quality" R&D is funded. Such an exemption is unacceptable if high standards are to be maintained.

MANPOWER PLANNING (3.110)

Previous attempts at manpower planning for Clinical Scientists have been flawed, figures provided by NHS Trusts and used by the NHS being substantially at odds with those collected by professional bodies. CSTI HCSAC would be willing to assist the NHS in manpower planning by making available detailed manpower figures provided by member organisations.

20 January 1995

Evidence from the Engineering and Physical Sciences Research Council

Following the UK Government review of science, engineering and technology ("Realising Our Potential" Cm 2250 HMSO 1993), the Research Councils in the UK have been re-organised as from April 1994. Support for research and postgraduate education in engineering and the physical sciences, including medical engineering, is now the responsibility of the Engineering and Physical Sciences Research Council (EPSRC). The EPSRC's objectives are to promote high quality basic, strategic and applied research and related postgraduate training, to advance knowledge and technology and provide trained engineers and scientists to meet the needs of users, to contribute towards the economic competitiveness of the UK and the quality of life of its citizens and to provide advice, disseminate knowledge and promote public understanding of science and engineering.

EPSRC provides more than £5 million per annum for medically related research. The majority of this is in three areas:

Medical Engineering:

The aims of the medical engineering programme are: to understand the engineering principles of the human body; to support diagnosis and clinical medicine; to support the treatment of disease and the development of devices; and to underpin the medical devices and medical instrumentation industries. It includes research on biomaterials, biomechanics, cellular/tissue engineering, imaging, implantable devices, medical informatics, physiological measurement/sensing and rehabilitation engineering.

Chemistry

Structural function relationships of biologically active compounds and bioinorganic chemistry, such as platinum compounds used as anti-cancer agents.

Medical Informatics

Computer science, imaging and lasers for diagnosis and treatment.

There is close interaction with the Medical Research Council and the Department of Health in all areas. A concordat with the Health Departments was signed on 30 January 1995. This is expected to lead to even closer working with the Department of Health and the National Health Service.

Within the Medical Engineering programme the biggest single funding (approximately £1.4 million per annum) has been to the IRC (Interdisciplinary Research Centre) in Biomedical Materials. The IRC is based at Queen Mary and Westfield College together with the London Hospital Medical College, Royal Free Hospital School of Medicine and the Institute of Orthopaedics at the Royal National Orthopaedic Hospital. The overall objectives of the IRC include a role as a centre for training in biomedical materials as well as acting as a national focus for research and development and, through an industrial affiliates club, facilitating technology transfer. The research programmes are aimed at progressing innovative materials from concept to patient. The main research is divided between four programmes:

bone and joint replacement materials

development of hydroxyapatite reinforced polymers, biodegradable polymers and composites, optimised bone cement, orthopaedic alloys, articular cartilage characterisation and replacement and aspects of cell biology and biochemistry;

orthopaedic systems

joint prosthesis, ligament, tendon and disc replacement and anchorage, bone-fracture fixation and experimental implantation and retrieval;

cardiovascular devices

Arterial tissues and cardiovascular materials together with cell biology of the design of new haemocompatible biomedical materials;

dental applications

dental implants are the main focus, but there is also work on reinforcement of denture base polymethylmethacrylate and other restorative polymers, drug delivery systems for heterocyclic/cyclic methacrylates and soft lining materials.

Within the Medical Engineering programme the rest of the funding (about £2 million per annum) is split between research into diagnostic imaging equipment, implants, surgical equipment, cellular engineering, rehabilitation therapy, clinical decision support and sensors for medical applications. Some 26 university departments are involved in this research and much of it is interdisciplinary.

The programme's declared aim is to promote and support research and education which enhances the application of science and engineering to medicine. The opportunities which will arise along the route of diagnosis and screening to accurate and effective therapy will be developed to produce a general advance in the health of the nation. Specific priorities are cellular engineering, molecular sensors, functional imaging and decision support systems. Cellular engineering includes growth and engineering of biological materials, cell guidance and networking, cell culture technology, tissue engineering and cell energy interactions. The molecular sensors aspect encourages research, not only into an understanding of the physical, chemical and biological processes occurring at the sensor/system interface, but also the problems of fabrication, encapsulation, ruggedisation and biocompatibility. The development of new techniques for producing anatomical images has led to new image manipulating methods and especially the creation of images in real time. [A major project has recently been funded at the Royal Observatory, Edinburgh, Edinburgh University and Manchester University to adapt software developed for astronomical research for use in examining mammographs for breast cancer screening.] It is expected that advances will be made using a variety of techniques for producing images of the physiological functions of the body and its constituent tissues. Decision support will include both advances in instrumentation to process patient data and the creation of databases and expert systems to assist clinicians in diagnosis and patient care.

The LINK programme in Medical Implants has successfully committed £5 million of funds from EPSRC, BBSRC, MRC, DTI and the Department of Health in the areas of replacement joints, cardiovascular devices and dental implants. There is also a LINK programme in Molecular Sensors, which has a broad remit including the development of sensors specifically for medical research. The programme has committed £5.5 million of government funds over five years, but is now closed to new projects. It was supported by EPSRC, BBSRC, DTI and the Department of Health. Proposals for a new LINK programme in Medical Devices, led by the Department of Health, are under consideration.

Within the Materials programme, there is also some funding, through the Nanotechnology programmes and the recently announced Surface Engineering LINK programme into surface coatings and treatment of surfaces particularly for implants.

Other areas of the EPSRC research programme are related to health and medical research, in particular Chemistry and Information Technology. Research in support of the pharmaceutical and diagnostics industries is funded through the Chemistry programme, including some in biomolecular sciences (a programme jointly funded with BBSRC). Of particular importance to the pharmaceutical industry is chiral chemistry, since optically pure compounds are more biologically active and mixed isomer compounds can have unfortunate side effects as shown by the problems of thalidomide. Development of these single enantiomers calls for novel chemistry and increased use of analytical techniques. The rewards can be considerable as the world market sales of enantiopure drugs topped £35 million in 1993. This area has a LINK programme supporting 73 projects and using £3.75 million of government funds over five years.

Within the Information Technology programme some £300k per year is spent in grants involving the visual representation and modelling of clinical images from radiology and other scanning devices. In addition there is some underpinning research in computational approaches to studies of human cognition (auditory as well as visual). A recently announced LINK programme in Photonics is considering support for a number of projects in the use of lasers for diagnosis and treatment.

The Medical Engineering and related science and technology research and training funded by EPSRC is vital underpinning for the health and wealth of the nation. While small compared to the funding of the MRC, it is a vital complement to the programmes of that Council especially in those areas where interdisciplinary research is important and where the transfer of technology from other sectors is advantageous.

Evidence from Guy's and St Thomas's United Medical and Dental School

UMDS would wish to support the evidence given by the Council of Deans of Medical Schools to the House of Lords Select Committee on Science and Technology on Medical Research and the NHS Reforms. In addition we would wish to draw their lordships' attention to a specific issue which has arisen in relation to the St John's Institute of Dermatology. Their lordships will be aware that St John's was a Special Health Authority until the mid 1980s when it moved to St Thomas' Hospital bringing its funding with it.

The introduction of the changes in hospital funding pose particular problems for large departments which are in undergraduate hospitals but whose focus is primarily on postgraduate education and research. As such they enjoy neither the protection of SIFTR funding in any significant degree—nor the price protection built into the postgraduate Special Health Authorities. St John's is a very clear example of this problem which is recognised to be a transitional one until the recommendations of the Culyer Report are implemented. UMDS and the Guy's and St Thomas' Trust are seeking ways in which St John's can be protected until such time as it is possible to bid for Culyer funds. Our initial request for core funding on a similar basis to the other Special Health Authorities has not been accepted and we are now seeking agreement that part of the Trust's transitional funding should be earmarked for St John's in order to provide such core funding until the Culyer market comes into effect. Our estimate of the amount of excess NHS costs which relate to St John's research and development activity is £2.3 million per annum. These are over and above what would be expected to be incurred by a normal Department of Dermatology in a teaching hospital.

St John's Institute of Dermatology is the only Institute of Dermatology in the United Kingdom and has a major role in research and development, as well as postgraduate training. It is also a major player on the international scene and attracts approximately 40 postgraduates each year from all parts of the world.

Implementation of the internal market and the resulting cuts have already resulted in the withdrawal of funding of core research staff from St John's. UMDS considers it essential that this unique national asset for dermatology should be protected until such time as it can bid from the funds for research and development support.

C Chantler
Principal

27 January 1995

Evidence from the Heads of University Centres of Biomedical Science

HUCBMS

The Heads of University Centres of Biomedical Sciences group was formed in 1992 so that the many new departments could benefit from a forum and share ideas. The first degree course was founded in 1975 at the University of Bradford, whereas in 1995 about 35 institutions offer degree courses in this subject and most of these departments contain research-active staff working in a wide range of subjects relevant to the Culyer Report and the NHS.

GENERAL COMMENTS

The Executive Committee of HUCBMS welcomes the Culyer Report on "Supporting Research and Development in the NHS".

Most of our member institutions already stress research and development in relation to the NHS within our degree courses. Indeed, many of our graduates continue their education by studying for research degrees (MPhil and PhD) before going on to work for the NHS, the Research Councils, Medical Schools and the pharmaceutical industry.

Our member institutions also publish extensively in health-related research often commissioned by Regional Health Authorities or the Research Councils.

It is important, therefore, that any funding that is to be provided should recognise departments of biomedical sciences as providers of research rather than confine funding merely to medical schools. To this end many of our member institutions have close collaborative links between their own academic staff and clinicians within the NHS and medical schools.

In conclusion, the institutions comprising HUCBMS strongly support the recommendations contained within the Culyer Report and wish to actively participate in wide ranging medical and health-related research that might be supported by this funding.

Professor T G Baker, FRCPath, FRSE
Chair of HUCBMS

Letter from the Imperial Cancer Research Fund

You requested data on the effects of charging for ECRs on referrals to the Soft Tissue Unit at St. Thomas's. This Unit used to offer a diagnostic service for problematical soft tissue tumours, an area whose difficulty I do not have to emphasise.

You can readily see the reduction in UK referrals since charging began, and the attempts by hard-pressed pathologists to gain opinions via the ICRF.

Since, in 15 per cent of these referrals, the referring pathologist has made a major error (benign/malignant) affecting patient management, any reduction in referrals could mean major problems arising from misdiagnosis (vice Birmingham!).

Professor Nicholas Wright
Director of Clinical Research

24 January 1995

Letter from Professor C D M Fletcher, Guy's and St. Thomas's Medical and Dental School, to Professor N A Wright, Imperial Cancer Research Fund

RE: SOFT TISSUE TUMOUR UNIT

Many thanks for your continued interest in the deleterious effect of the NHS reforms on the activities of our specialist Unit and for speaking to Lord Walton about this.

Enclosed now are the figures that you requested in the form of a table and two graphs. The following are salient points:

1. Compulsory classification of all our NHS referrals as tertiary ECRs was introduced on April 1st 1993. The abrupt drop in referrals was therefore first noted in the 3rd (not 2nd) quarter of that year since, initially, referring pathologists were unaware of the new arrangements until they actually sent a case.
2. The fall in UK referrals (compared to the peak in 1992) is 27 per cent. If you note that, prior to that time, the referrals were showing an annual increase of more than 20 per cent (and there was no suggestion that we were anywhere near to reaching a "ceiling" figure) then this recent fall is even more significant.

3. Proof that the referrals should have continued to increase (rather than level out) comes from the fact that the overseas referrals have continued to increase substantially each year.

4. The corollary of point 3 (as you'll see from the table) is that almost two thirds of this Unit's work now relates to foreign patients. Such work is, of course, totally unbillable (or, at least, billing would rapidly destroy it) but once upon a time would have been regarded as a credit to the NHS, particularly since the Unit costs are low.

5. You'll notice that referrals from your own ICRF/RCS Referral Unit escalated by 100 per cent in 1994. This can only imply that at least some pathologists are trying to obtain opinions from this Unit via the back door, thus avoiding any cost. This leaves the ICRF liable in theory to direct bills of £219 per case (Total £26,280 in 1994). While the administrators at St. Thomas's regard this as nonsensical and have therefore not continued to try and bill your charitable body, there is no certainty at all that the NHSME hold similar views and furthermore this is still listed as a "loss" by our finance department.

6. To this day most pathologists (I suspect most doctors) in the UK have no idea how the ECR system works, which in itself is a deterrent. Despite claims to the contrary the NHS have made no attempt to educate users nor to simplify this bureaucratic system.

Anything Lord Walton can do to draw attention to this travesty will be greatly appreciated. (Remember that in 15 per cent of all our referrals the primary pathologist has initially confused benign and malignant with potentially very major clinical implications).

All best wishes and thanks as always.

C D M Fletcher

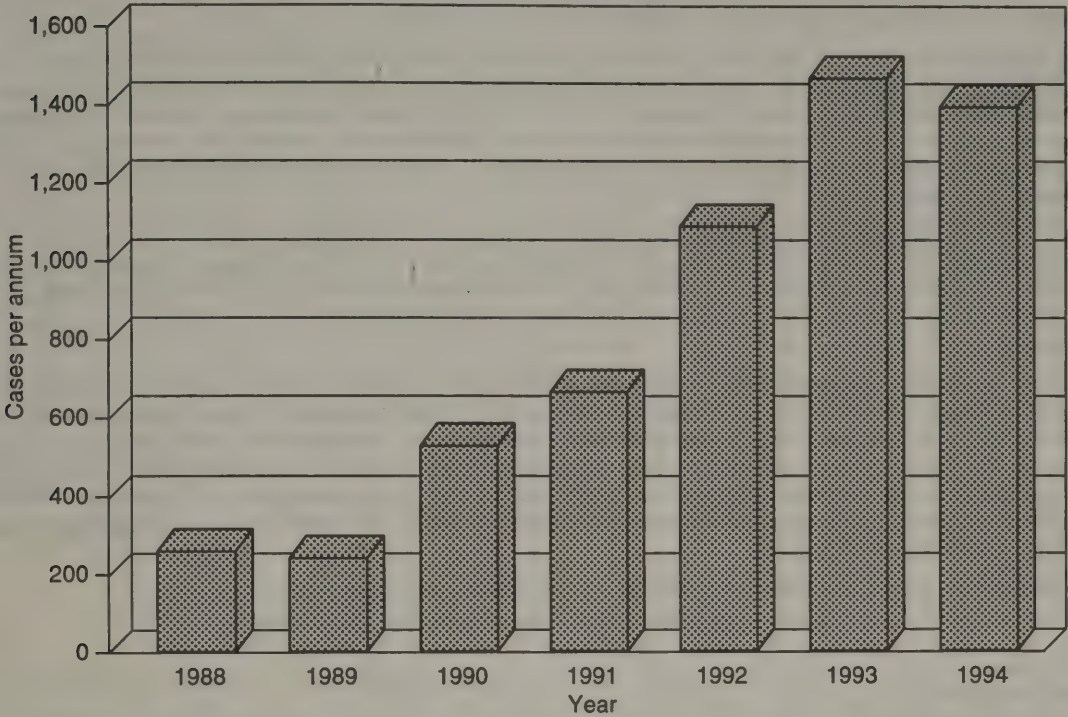
Professor of Surgical Pathology, UMDS.

13 January 1995

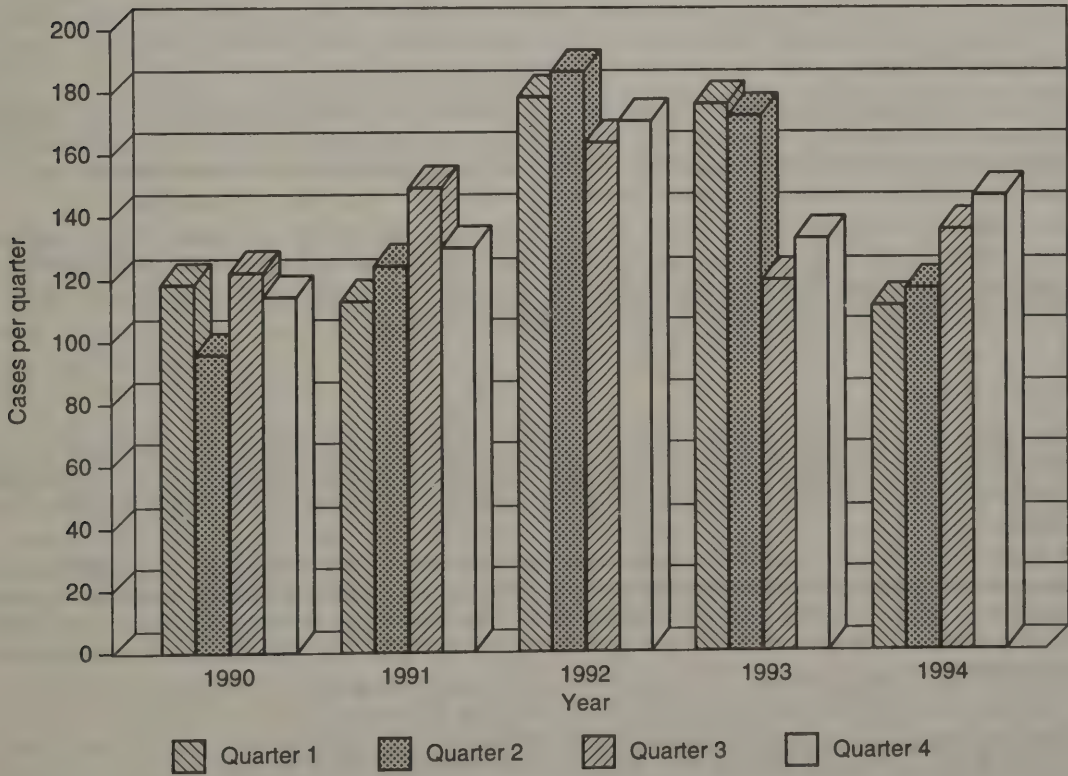
Diagnostic Referrals to Soft Tissue Tumour Unit, St. Thomas's Hospital, London

	<i>Total Cases (all sources)</i>	<i>Total UK Referrals (% of overall total)</i>	<i>ICRF/RCS Referrals (% of UK Total)</i>
1989	238	209 (88%)	31 (15%)
1990	541	451 (83%)	50 (11%)
1991	676	511 (76%)	46 (9%)
1992	1080	693 (64%)	49 (7%)
1993	1440	601 (42%)	59 (10%)
1994	1393	506 (36%)	120 (24%)

**Diagnostic Referrals to Soft Tissue Tumour Unit, Department of Histopathology,
St. Thomas's Hospital, London**



**U.K. Referrals to Soft Tissue Tumour Unit, Department of Histopathology,
St. Thomas's Hospital, London**



Letter from the Institute of Biomedical Science

The Institute is pleased to have been given the opportunity to comment on the NHS Research and Development Strategies, and wishes to make the following comments.

It is appreciated, that in the current market driven environment of the National Health Service there is a significantly greater pressure on research and development budgets. Nevertheless, the range of proposals put forward for research is impressive. However we would like to draw attention to the benefits of smaller projects, such as comparative studies in non-clinical areas, which deserve attention for the benefits that they may bring in patient care, economies, and in staffing benefits. Research can also have additional benefits in terms of staff motivation.

The Health Service, particularly through the professions, has potential benefit from a network of establishments and individuals who are able to set up multi-centre trials and projects. These need not by nature be of the sophisticated double blind type, but those where professionalism can be guaranteed by the standards of the staff involved. Such activity would represent independent advice devoid of commercial pressures.

There must always be some place for curiosity driven research, and the Institute would therefore propose that not all the monies put aside for Health Service Research should be targeted to large projects directly and that a small, yet significant sum be set aside each year for open competition to facilitate less ambitious projects. The Institute recognises that current budget constraints are such that projects are likely to become less readily available as laboratories seek to recover the full cost of all investigations. To centralise all such activity on large regionally directed projects has a considerable risk of losing the enthusiastic involvement of many competent professionals.

The Institute would be pleased to elaborate on any of these particular points.

A R Potter
Chief Executive

31 January 1995

Evidence from the Institute of Physical Sciences in Medicine

IPSM evidence on the three questions is as follows:

1. NHS R&D STRATEGY

The Institute supports the concept of a centrally commissioned programme targeted on matters of specific NHS concern. However, it is important that the programme is not dominated by concerns of the moment, to the exclusion of longer range opportunities. The roles of the Regional Research Committees and Regional Directors of R&D are similarly supported but some extensions are suggested under question 2 below.

The Institute is concerned that the term 'Health Technology Assessment' has been coined to describe activities which in many cases will contain nothing which the man in the street or the dictionary would recognise as technology. This unfortunate term would allow NHS spending on technology to be over-estimated even though it supported little or no technological activity.

2. CULYER REPORT

The Culyer Report sets out a clear framework within which academic research can be supported and touches on the problems of supporting curiosity-driven research in NHS. Unfortunately, no firm foundation for funding the latter is identified by the report beyond reliance on discretionary support by Purchasers and Providers.

Without further attention the lack of a firm foundation is likely to destabilise this area of R&D. If the discretionary support of Purchasers and Providers is to be the only source of funding for curiosity-driven research, it is essential as a minimum that Purchasers and Providers agree a policy and plan in consultation with their Regional Director of R&D and that the latter monitors the implementation of the plan by receiving reports.

3. ADDITIONAL CHALLENGES AND OPPORTUNITIES FOR UK MEDICAL RESEARCH

Curiosity-driven research carried out by Clinical Scientists is fertile ground for the cultivation of new technological solutions of medical problems. Technology transfer is an effective means of propagating the benefits of these solutions throughout the NHS and beyond. It is therefore a potent means of implementing the findings of research. A company which licences production of medical devices developed by Clinical

Scientists, has every incentive to ensure their take-up in health care wherever practicable. An NHS hospital considering purchase of such devices will not do so unless the benefits appear to justify the cost.

The Institute of Physical Sciences in Medicine is very concerned at the low level to which UK medical equipment industry has declined and proposes to address this by bringing SMEs into contact with the innovations produced by curiosity-driven research in the NHS. One method of achieving this will be an "Innovation Trade Fair" for market-ready technology conducted under conditions conducive to licensing for production.

In the NHS Strategy and the Culyer report, industry appears as a source of funding and collaboration for NHS and clinical research but this role is only appropriate to the large industrial players, which in UK means the pharmaceutical industry. However, the future of our medical equipment industry (if it has a future) lies with SMEs and must be regrown from seed. The ability of SMEs to collaborate in R&D is extremely limited but they can readily licence the products of NHS R&D and market them in competition with the rest of the world.

This challenge and opportunity is not strongly represented in the NHS Strategy or the Culyer report but the Institute believes it is one which the NHS will wish to accept and address.

Dr J K Haywood
President

25 January 1995

Evidence from the Institution of Mechanical Engineering

1. *What is Your Assessment of the R&D Strategy?*

The forceful implementation of a clear strategy is seen as essential to effective progress. In that, we welcome the recent changes towards more central direction and control of resources. Many engineering projects require large efforts to prosecute in a professional manner, and these changes should prove enabling towards the more significant developments which were previously funded direct from the Department of Health.

One particular concern of the IMechE is for the continuity of development engineers employed as clinical scientists in the NHS and university staff who have committed their research careers to medical engineering. Whilst we appreciate the need for the evaluative culture at this time, a complete cessation of funding for research and development projects in medical technology would jeopardise the continuing existence of this group. Such expertise cannot be easily re-assembled at the appropriate time. Many of this group have readily changed their emphasis to participate in the newer profile of evaluation work, but cannot sustain this position indefinitely.

We request that a proportion of funds be clearly identified for research and development of medical technology.

2. *What is Your Response to the Culyer Report . . . ?*

Again, the recommendations are well-received. In view of our remit, we confine our comments here to one item which is crucial to mechanical engineers working in the NHS. This relates to recommendation 15, and in particular to item (c), which identifies the "*costs of maintaining particular research facilities and staff which enable R&D projects and programmes to take place . . .*".

Whereas in the past many teaching hospitals have supported small mechanical workshops with the capability to undertake both routine biomedical equipment maintenance and small development projects, this system is under severe strain. Increasingly, equipment maintenance is being subcontracted, partly as a result of the general move to market test support services and partly due to new standards which are harder to meet in small in-house facilities. Trust hospitals are quickly identifying that the remaining costs cannot be related to patient episodes. NHS workshops must then be seen to recover full costs of the work they undertake under R&D contracts. Difficulties lie at present with full cost recovery from NHS-funded contracts, and in providing a satisfactory cash-flow within a zero-budget accounting system. Security of employment for workshop staff is thus unacceptably low.

Many NHS-funded R&D projects require the services of an Engineering Development Service, which term is taken to include not only mechanical and electronic workshops, but also associated design and development facilities. Even the drilling of an additional hole to mount an extra plug in the casing of patient-connected equipment cannot legally be undertaken without formal consideration of European EMC (Electromagnetic Compatibility) and GMDD (General Medical Devices Directive) regulations! A medical Engineering Development Service will be familiar with all the relevant standards, which neither a university set-up nor a small jobbing workshop will normally be. It is our belief that many industrial SMEs could also benefit from access to such facilities in the process of technology transfer from research laboratory to

industry. We contend that the loss of in-house medical equipment development facilities would prove in the medium to long term a real impediment to NHS R&D.

We request that consideration be given to the baseline funding of a network of Engineering Development Services within the teaching hospitals, which can service the needs of NHS-funded and other medical research and provide a costed service to UK industry.

3. Do you identify challenges or opportunities for UK Medical Research which neither the NHS Strategy nor the Culyer report addresses?

The IMechE Engineering in Medicine Committee wishes to address two issues relating to facilitation of commercial success from R&D effort.

- (i) Neither the NHS nor the Culyer report addresses the relationship between NHS research and UK medical industry. R&D in this industry is unique in that it generally requires clinical access at the applied research, development and acceptance trial stages. The NHS, as the major home purchaser, should assume a responsibility for participation in this process for two reasons. The first is to have a hand in shaping the future products which the NHS requires, whether these be the fruit of NHS-funded research or otherwise: this is of direct benefit to the NHS and its patients. The second reason is to ensure the continued viability of the UK medical engineering industry. Although the latter is seen to be of less direct benefit to patients, the NHS as a government-funded agency must act responsibly in this regard. We would contend though that in the long term the NHS will be held to ransom over the cost of equipment by the loss of its home suppliers if medical industry is lost.

Larger companies make direct access to a wider group of selected clinicians to pursue their clinical needs, and are also able to fund their trials privately. We would however draw attention to the predominance of SMEs in the remaining UK medical industry: in their smaller-scale operations, they may fall into the trap of obtaining clinical input which is too narrow, and almost certainly will not have a bioengineer of sufficient experience on the staff to make a proper evaluation of clinical aspects. The comprehension of the NHS R&D priorities, health care needs and service delivery aspects is also less than complete in many SMEs, who have not had access to the debating forums on these issues. In this context, it is possible that the Engineering Development Services proposed earlier in this document could act as the primary link between industry and the NHS clinical facilities.

We request that the NHS develop a clear strategy for industrial liaison in R&D, which includes appropriate routes of access to clinical services and sympathetic support for mutually-beneficial developments particularly for smaller companies.

- (ii) If the NHS is to realise the commercial value of its funded work, then the issue of *Intellectual Property Rights (IPR)* is in urgent need of attention. Some of the current problems are
 - Perceived academic merit in universities: The Higher Education Funding Council England categorise research funding into “quality”, “generic” and “contract”, with both funding and merit implications. NHS R&D funding is by and large categorised least favourably as contract research, based on two conditions in the standard contract: briefly, the exclusive retention of all IPR, and the need to seek permission to publish. Such treatment does not provide best motivation and academic support for the researcher.
 - Motivation for technology transfer. Successful commercialisation normally depends on the strenuous and enthusiastic efforts of the research team, which may not be secured without shared ownership of IPR. Under current arrangements, successful teams lose control of their developments and have low motivation to press for technology transfer. The philosophical issue here should surely be how to encourage commercialisation of successful research to the overall benefit of NHS patients, and not exclusively to the benefit of NHS coffers. This may require a more liberal arrangement to elicit initiative from those most likely to act—usually the researchers.
 - Routes to commercialisation: The NHS is not a body well set up to provide this. Trusts in particular are inexperienced and unrealistic about technology transfer issues, underestimating the energy and time needed to realise a commercial gain following an R&D advance, and without experience in handling the process. Although the established path via the British Technology Group is appropriate and expeditious in some cases, this single route is limiting and should be a preferred option rather than compulsory.

Equitable arrangements can be made to benefit and motivate both the NHS and the R&D providers. This can be done in keeping with the best practices of other government agencies more familiar with IPR issues, eg the DTI, or in line with the Research Councils’ more liberal policies.

We recommend that the NHS and Department of Health urgently revise their policies on Intellectual Property Rights in the light of the current government’s policy to encourage individual enterprise.

Evidence from King's College School of Medicine and Dentistry

I write as one long experienced in dental research in the United Kingdom and abroad to ask that their Lordships give attention to the following matters in their assessment of NHS reforms and the Culyer Committee on medical and dental research in the United Kingdom:

1. Underfunding. Research into matters dealing with oral and dental health is, I have estimated from various sources, currently funded in the United Kingdom to approximately £1.8 million per annum. This is a tiny proportion of the cost of NHS dentistry which totals £1,600 million per annum in the General Dental Services alone. This is at least an order of magnitude less than the 1.5 per cent of NHS expenditure targeted for R&D within the NHS as a whole. Application of the same formula to dental research would revolutionise the UK scene.
2. Dental research in the United Kingdom enjoys a high national and international reputation for quality. However its volume is declining as is its influence, in line with the general decline in British science as a result of declining R&D expenditure from all sources. There is time to reverse the trend.
3. Most of this research is done in Universities with dental teaching schools. An adequate floor of support is essential for the research base to be maintained. The R contribution of SIFTR has been inadequate in the past. The Culyer report provides an opportunity to put this right but this is only likely to happen if there is adequate representation of academic dentistry on the decision making pathways.
4. There needs to be a cultural shift in the United Kingdom which recognises the importance of oral health research and generates an adequate career structure for those who wish to dedicate their lives to it. This needs input from the health departments, the higher education funding councils, the research councils and medical charities. At the present time academic staff in dental institutions are far too heavily committed to teaching and the supervision of undergraduate students to provide adequate time for research. There also needs to be improved training and education for the researchers.
5. Their Lordships might like to start a dialogue with the Department of Trade & Industry over the difficulties created by the lack of a manufacturing base for dental materials and equipment in the UK—sadly an area in which British industry was once strong. The fostering of links between industry and academia could be beneficial; major international oral health care companies want this and the DTI could perhaps help.

I should be happy to provide more detailed evidence if their Lordships please.

Professor N W Johnson

29 December 1994

Evidence from the Leukaemia Research Fund

1. *What is your assessment of the NHS R&D Strategy?*

The NHS R&D strategy is being formulated by what appears to be a very complex administrative structure radiating out from a central R&D directorate with its Central Research and Development Committee and Advisory Groups embedded within the NHS Research and Development Division. In addition to this there are regional directors of R&D each with their own management structures, regional committees (of up to 20 members), regional networks, regional peer-review committees and regional commissioning groups. This must be a very expensive infrastructure to maintain.

Anecdotal information suggests that for the present there is less than £30 million per annum available for Professor Peckham and his regional directors to spend on research. If Professor Peckham's budget is increased substantially by the transfer of the "R" component of SIFTR to the NHS R&D directorate then we will be in a better position to assess how effectively this organisational structure can work.

I have two main reservations about the present system. The way international standard, innovative research programmes evolve and are sustained is essentially determined by two parameters. One is the quality and vision of the research programme itself. It is difficult to see how regional peer-review committees will be truly impartial and objective in their assessment of the quality and value of research applications. The Leukaemia Research Fund has taken great care over the past five years to restructure its peer review mechanisms and we now call upon many overseas experts for advice. Additionally we have excluded all major LRF grant holders from our grant awarding committee and any involvement in assessing each other's research performance. We continue to look for ways to remove any suggestions of bias, prejudice or vested interest in our funding programme. There is no doubt that this has considerably strengthened the quality of the Fund's research portfolio.

The second parameter is the coming together of the right individuals, in the right place, at the right time to carry out an agreed programme of research. This can be more difficult to achieve than devising the research

project and is often due to serendipity. It is difficult to see how endless policy papers, strategic reviews and commissioning teams can truly influence these basic tenets. Equally it will be interesting to see how rapidly this complex administrative infrastructure can respond to new directions and innovations in biomedical research.

2. What is your response to the Culyer report on "Supporting Research and Development in the NHS"?

Not unreasonably *laboratory-based* cancer research is not a high priority for the NHS R&D programme. This is because the three major UK cancer charities, the Imperial Cancer Research Fund, the Cancer Research Campaign and the Leukaemia Research Fund, together with some input from the Medical Research Council, invest well over £100 million per annum in research. However for this massive research effort to have patient benefit there must be a seamless integration between laboratory science and the clinical service. This is achieved most effectively in the regional centres of excellence, ie, the teaching hospitals and tertiary referral centres, where there is a judicious mix of scientific and clinical skills working in a well-resourced environment. It is absolutely crucial that if the "R" component is uncoupled from SIFTR it must be protected and targeted to maintain the infrastructure of these research centres.

Cancer research in the clinical arena, for example involving trials, diagnosis, imaging, and transplantation carries an indirect cost component that has previously been paid for (it is assumed) by SIFTR. Within the new NHS with its purchaser-provider ethos this is no longer certain. One illustration of this uncertainty is the difficulty of maintaining clinical trials for cancer patients which were well described by Smyth et al in the *Lancet* last year. The concern is that the "R" component of SIFTR has been used to hold down the cost of the clinical service provided by teaching hospitals and other specialist centres rather than underpin research. If this money is truly committed to research then proper mechanisms must be put in place to ensure that the centres of excellence are protected. There are clear signs that the biomedical charities are being pressurised to provide surrogate funding for components of clinical research that should really be provided by the NHS Trusts. For example in recent times the Leukaemia Research Fund has been asked to pay for the rental of office space, the cost of the telephones and stationery, the use of computing time and the administrative costs of local ethical committees, all of which in our opinion should be provided from SIFTR, or as intended in future, from the NHS R&D budget. This should be analogous to the biomedical charities role within Universities and Research Institutes where the direct costs of research are provided by the charities and the support infrastructure is provided by the Higher Education Funding Council. To continue this analogy further the Culyer report proposes that hospitals carrying out clinical research should be assessed in a similar way to that conducted by the Funding Councils for universities. Certainly some means of assessing excellence in clinical research would be welcome in order to ensure the most cost-effective way of distributing "R". However it would be disappointing if the government felt it necessary to set up another agency to conduct a hospitals research selectivity exercise. It should not be beyond the capabilities of the NHS R&D directorate to provide basic measures of excellence to its funding committees. This reinforces the need for transparent and effective peer-review procedures.

3. Do you identify additional challenges or opportunities for UK medical research which neither the NHS strategy nor the Culyer report addresses?

All funding agencies are preoccupied with working within strict research budgets whilst supporting ambitious research programmes. For the future the emphasis must be very much on partnerships. It is rare that any one funding agency can exclusively support a major programme of research. It is welcome therefore that the Culyer report recommends the creation of a national forum to co-ordinate research in the NHS. However the very different working practices and agendas of the NHS, the research councils and the biomedical charities will be difficult to reconcile within such a forum. The emphasis must be on co-operative partnerships so that the whole is greater than the sum of the parts. One example where this will be important is in the development and assessment of gene therapy as a feasible therapeutic strategy.

Evidence from Lewis-Emerton Associates

Assessment of the NHS R&D Strategy—I support the aims, objectives and the general approach of the development of the strategy. In particular I am convinced that this strategy, in conjunction with the FORESIGHT PROGRAMME to guide the content of the Science Research Councils' programmes funded by the Office of Science and Technology, can help to improve patient care. Furthermore, I am convinced that the efforts of the current Director of the R&D Division to encourage closer and more effective co-operation between NHS and UK Manufacturers of Equipment will be to the benefit of patients and to the competitiveness of this sector of Industry.

The last ACOST Report continued to highlight the poor record in the UK of successful exploitation of Medical Science by British Manufacturers. I am pleased to note from today's announcement of MEDLINK that this key recommendation of ACOST has been put into effect. Unfortunately, ACOST suggested that MEDLINK should be based in the Innovation Unit within the DTI rather than in the Department of Health. I am not clear why the DTI was not able to undertake this task themselves.

I am of the opinion that there are several other opportunities which will require inter-departmental co-operation, which will greatly add to the R&D Division's efforts to improve co-operation between Industry and the NHS. I would respectfully suggest that the following initiatives be supported.

- To review the beneficial effects of NHS Purchasing Role in helping to establish equipment suppliers credibility in World Markets. In this respect healthcare financial assessments could be an invaluable precursor activity. It should be possible for the NHS to emulate the successful way that the Ministry of Defence has greatly aided the UK Defence Industry.
- Greater efforts to recruit from manufacturers, particularly from Small to Medium Size Enterprises, members to sit on the Research Liaison Committees—not only by the R&D Division, but also on the healthcare related panels of the FORESIGHT PROGRAMME.
- To improve the network of effective contacts between the Medical Equipment Suppliers and the NHS, by enabling all of the NHS agencies to access, and be accessed by the evolving national network of 'Business Links'. Indeed it could be argued that the R&D Division of the NHS should be the Medical Node in the DTI's SUPERNET. This could greatly help manufacturers to be aware of European Requirements and to better 'harvest' ideas for new equipment which are generated within the NHS.
- To improve the management of R&D Projects being conducted at the basic research or clinical trials stages of new product development within the NHS by using established examples of Good Management Practices arising from the M90's programme in the DTI. At the very least, improved project management will reduce development time, and maximise the outputs from such projects for a given level of overall spend.
- To better enable the skills and capabilities within NHS Agencies, particularly NHS Estates, NHS Supplies, Medical Devices Agency, together with Agencies in other government departments to more easily co-operate with UK Manufacturers in applied research projects. This will require funding which could be generated through royalty payments from UK and Foreign Manufacturers when they exploit the fruits of basic research funded through OST as well as the product-related applied research referred to above.

It is important to reinforce the general awareness by industry of the Regional Directors of R&D. The necessary development of effective co-operation between the NHS and Manufacturers can be greatly helped through Regional bodies such as the Welsh Medical Technology Forum or The Yorkshire and Humberside Medilink. Unfortunately, with the recently publicised 'down-sizing' of the RHA's, there is a perception that the Regional Directors of the R&D have had their remit reduced. I believe that Recommendation 8 on page 8 in the Culyer Report could be used to remedy this problem.

James E Smith OBE
Senior Partner

31 January 1995

Letter from the Medical Journalists' Association

The Medical Journalists' Association broadly welcomes the recommendations of the Culyer Report. But the Association has concerns about how the recommendations are to be implemented, and lists these below.

IDENTIFYING SIGNIFICANT R&D IN THE NHS

The proposed national database of NHS research should be accessible to anyone who uses the NHS. A directory of the main research projects should be sent to the head public library in every town or city. This should list the aim of the project and how it will benefit peoples' health, the name and institute address of chief researcher, amount of funds awarded, including the extent of any commercial sponsorship from the manufacturers of pharmaceuticals or medical equipment. Industry sponsorship should not be sought for the creation of this database. It will be a world first in the wealth of data it contains and too precious to risk loss of its independent status or of restrictions in access.

OPEN DECISION-MAKING ON R&D INVESTMENT IN THE NHS

As the general public pays for the NHS, everyone must be carefully consulted in order to draw up representative principles and criteria which will guide the use of NHS funds for R & D. Questionnaires placed in every GP's surgery could ask patients to assign scores on the importance of research into different diseases, and open questions would be needed to find the general consensus on what the guiding principles should be. Once compiled every household in the UK should be sent a copy of the research "principles and criteria" publication. If this is a long document a summary would suffice, pointing out the nearest library where the

full document could be consulted. This publication should list a contact in each health region who is responsible for local priorities and who will disseminate a complimentary publication explaining why certain research projects are especially important for particular districts.

RESEARCH PRIORITIES

The MJA welcomes the implied role of the NHS R&D programme to make sure research continues into the long-term health problems of patients such as the mentally ill. This role must be made explicit along with a commitment to cover "Cinderella" disease areas which would miss out of a programme driven only by the lobbying power of large medical institutes, associations or medical charities. The MJA considers proper priority setting will require input from individual patients as well as consumer groups. As part of their quality of service auditing, health authorities should include questions on what areas of health, limited research funds be spent on. Research results must not be judged just on the ability to save money or lives. Practical ways of enhancing the quality of life that may not appear dramatic or significant to the research community, may transform the lives of patients.

FUNDING

Funding must be realistic and cover long-term objectives. Safeguards must be put in place so that money is not allocated for short-term political gain or for solely commercial reasons. Industry input can be valuable as long as it is in keeping with the long-term goal of improving the health of the nation. Guarantees must be made that substantial amounts of money go into research into disease prevention, new vaccines, alternative agents to market-leading drugs, and non-drug therapies.

It is encouraging that many large pharmaceutical companies are now offering, drugs, diagnostic devices and services aimed at helping clinicians manage all aspects of particular diseases. An example of this "disease management" approach is diabetes care. The same company will provide devices to diagnose the condition, various drugs to treat it, and a service which helps clinicians diagnose diabetes early and treat it effectively. This improves the quality of life in the long-term for patients with diabetes as well as saving the NHS the expense of dealing with complications. For the new NHS R&D strategy to work optimally, however, there must also be greater co-operation between government and industry. One example might be the increased use of "benchmarking". This would speed up the approval of new research-based developments, and offer a greater degree of transparency than has previously been known.

INFORMATION SHARING

The MJA is concerned that the emphasis put on competition and the commercial value of clinical knowledge, throughout the reformed NHS, will stifle the collaboration and co-operation that has earned the NHS its reputation the world over as the number 1 testbed for medical research.

We ask that the Subcommittee gives this matter deep consideration. One solution would be to call for legislation that ensures sharing of data from all major trials/studies.

Many medical journalists have expressed concern about hospital doctors being less free to talk about their NHS work. This is worrying as mis-information and mistrust are the most likely outcome of this development. Health statistics are becoming less easy to obtain under the NHS Trust set-up. For example, it is no longer possible to study closely childbirth patterns now that bed numbers are submitted for trusts and directly managed units, and not for individual hospitals.

Thank you for your consideration of the above evidence.

James B McGuigan Esq

On behalf of the Professional Affairs Subcommittee of the Medical Journalists' Association

3 March 1995

Evidence from the Medical Research Council

Our reply to your recent questions follows below; if you would like to discuss any of these points further, please let me know.

1. (a) The Council's definition of Health Services Research is: "The investigation of the health needs of the community and the efficiency and effectiveness of the provision of services to meet those needs". Under this heading, the Council spent about £4.4 million in 1993-94. The Council's total expenditure in the same financial year was £288.2 million (1.5 per cent). We have monitored this aspect of our expenditure closely over recent years (in accordance with the 1981 Concordat and its 1986 renewal). It has been rising slowly in real terms. Since the formation of the Health Services and Public Health Research Board in 1992, more HSR projects have been supported as a result of the

Board's proactive approach to increasing the quality and quantity of health services research and we therefore expect expenditure on HSR to rise a little more steeply over the next few years.

- (b) The Council's definition of Public Health Research is: "Research relating to the primary, secondary or tertiary prevention of disease and disability and to the health and well-being of human populations". This is a broad definition which could be interpreted to extend from for example quite basic work on the development of vaccines for HIV to studies of the prevalence of various forms of food-borne illness. There is also some overlap with HSR, as for example in the trial of cholesterol-lowering drugs to prevent coronary heart disease. It is therefore difficult to produce a precise and meaningful figure for expenditure on PHR quickly enough to be helpful to the Committee.

Overall, the council's commitment of HSR and PHR is increasing. These topics are extremely important components of our portfolio; they are the ones where it is most easy to develop the links between the research and improvements in human health and in quality of life which are the central features of the Council's mission.

2. The MRC welcomes the proposal to appoint an NHS Director of clinical trials for England and looks forward to working with Professor Stephen Holgate in that position and in the light of a clearer understanding of his responsibilities. The MRC expects to maintain a substantial commitment to clinical trials as a means by which the objectives of its mission can be achieved and in the light of its expertise and experience with UK-wide and international trials [see attached Directory of Clinical Trials—current and planned]—continuing to work jointly with the Health Departments. Council anticipates that the new appointment should assist with prioritising English needs for trials and facilitating provision of service support requirements.

3. The MRC welcomes the publication of interim arrangements for service support for MRC research, and hopes that the publication of these arrangements will ensure the provision of support required for the clinical trials (particularly those which are multicentred) and clinical research being planned, so that important trials are not jeopardised or delayed. It is naturally concerned to monitor the implementation of these new arrangements to see how they work in practice and to establish whether they deliver the support needed without excessive bureaucracy, particularly in relation to the support necessary to provide services or drugs that are being evaluated, and for support of clinical research of longer term relevance to the NHS.

4. It is too soon to be able to say what proportion of alpha rated proposals the MRC will be unable to fund for lack of resources in the 1994–95 session. However it is already clear that this is going to be a difficult year financially and therefore the proportion of alpha rated proposals that we will have to decline is likely to be significant and higher than in previous years.

I hope this information is helpful to the Select Committee.

Dr David Evered
Second Secretary

12 April 1995

Letter from the Office of Science and Technology

HEALTH CARE AND FORESIGHT

I am responding to your letter of 14 October on behalf of Mr Dale.

There are 15 sector panels involved in the Foresight Programme, and of these, the Health and Life Sciences panel is the most directly concerned with health care. The scope of the Health and Life Sciences sector encompasses a diverse range of markets, social needs, and technologies, including:

pharmaceuticals; diagnostics; general medical and veterinary equipment and supplies; non-medical applications of biosensors; medical procedures; health promotion and nutrition; management of health care; production of improved plant and animal strains, and biotechnology in manufacturing.

Health care is also relevant to the work of several other panels, most notably IT and Electronics, Chemicals, Food and Drink, Agriculture, Natural Resources and Environment, and Materials. We are promoting links between panels to ensure areas of common relevance receive proper consideration.

The Health and Life Sciences panel started work in May 1994, and over the summer developed preliminary ideas on the social, economic, and technological trends which will shape the sector, and explored the opportunities and problems which may result. The panel is now consulting widely through a programme of five regional workshops, a Delphi survey of about 500 individuals, and a consultation document sent to about 150 organisations and a selection of influential individuals.

It would be premature to speak of outcomes—however tentative—before the consultation process and subsequent deliberations are complete. The panel will present its conclusions and recommendations in a draft report to the Foresight Steering Committee in mid-January 1995; the report will be finalised by the first week of March.

Please do not hesitate to get in touch if you need any further information.

Declan Mulkeen
Technical Secretary, Health and Life Sciences
24 October 1994

Evidence from the Office of Science and Technology

INTRODUCTION

1. The Office of Science and Technology (OST) recognises the importance of high quality medical research. It is a prerequisite for progress in the diagnosis, treatment and prevention of human disease. Major breakthroughs in patient care are dependent on this research. As well as improvement in the quality of life for the nation, the exploitation of the results of medical research are of major benefit to British industry.

2. Today's announcement by the Chancellor of the Duchy of Lancaster on the allocation of the science budget for 1995–96 reaffirms the importance the Government attaches to medical research. The MRC will receive £277.8 million in 1995–96.

ROLE OF THE OFFICE OF SCIENCE AND TECHNOLOGY (OST)

3. In addition to its responsibilities for the Research Councils, OST plays a key role in supporting and shaping medical research in the UK. Many of the programmes and initiatives for which OST has responsibility include a strong medical dimension. For example, the Technology Foresight Programme includes a Health and Life Sciences Panel, chaired by Professor Mark Ferguson; and the LINK initiative will soon include a new programme on medical technologies.

4. The Council for Science and Technology (CST), chaired by the Chancellor of the Duchy of Lancaster, takes great interest in the future of medical research in the NHS. The Council met with Professor Peckham (Director R&D, Department of Health) and Mr Langlands (NHS Chief Executive) in May 1994 to discuss medical research and the NHS reforms. The Secretary of State for Health, accompanied by Professor Peckham and Mr Langlands, are due to join the CST at its next meeting in February, to discuss implementation of the Culyer Report.

5. OST has a close working relationship with the Department of Health. At ministerial level the Chancellor of the Duchy of Lancaster and the Secretary of State for Health have recently made joint visits to the Maudsley Hospital and to the Wellcome Trust. During their visits they were informed that clinical departments in Britain were more research oriented and intellectually rigorous than those in the US, where clinical income has become dominant. This is seen as an important factor in attracting world-class medical researchers to Britain.

6. At official level, OST maintains close and regular contact with the Department of Health. Sir William Stewart (Chief Scientific Adviser) and Sir John Cadogan (Director General of Research Councils) have met with Professor Peckham on a number of occasions to discuss the recommendations and implementation of the Culyer Report.

7. The Department of Health is represented on the official Cabinet Committee on Science and Technology (EDS(O)), chaired by the Chief Scientific Adviser, and provides an important input to the annual Forward Look of Government-funded science, engineering and technology, and the Technology Foresight Programme.

8. In addition, OST works closely with the Department of Health on a number of other issues. OST played a pivotal role in bringing together the funding partners (Department of Health, the Medical Research Council, the Biotechnology and Biological Sciences Research Council and Glaxo plc) of the recently established Edward Jenner Institute for Vaccine Research. The Institute will undertake basic research to underpin the development of new and improved vaccines. This represents an important example of partnership between Government, industry and the science base which should lead to significant improvements in the quality of life.

CULYER REPORT: "SUPPORTING RESEARCH AND DEVELOPMENT IN THE NHS"

9. OST welcomes the Department of Health's Research and Development Strategy¹ which is designed to contribute to the wider Government S&T objectives of wealth creation and quality of life.

10. The Office of Science and Technology (OST) is broadly supportive of the recommendations of the Culyer Report². Proposals for a National Forum (3.6), the recasting of the Central Research and

¹ "Research for Health" (Department of Health, 1993).

² "Supporting Research and Development in the NHS" (HMSO, 1994). A Report to the Minister for Health by a Research and Development Task Force chaired by Professor Anthony Culyer.

Development Committee (3.13), the establishment of a national database (3.91), and the formalisation of assessment ratings (3.57) should help better to coordinate R&D in the NHS.

11. OST also welcomes recommendations aimed at identifying and meeting the true cost of NHS research (3.60, 3.62 and 3.96). We are considering with the Department of Health how best to include details on the funding for NHS supported research and development in the annual Forward Look of Government-funded Science, Engineering and Technology, alongside a description of research strategy and programmes.

12. A change to a single funding stream, as recommended in the Culyer Report (3.28) should help simplify research funding in the NHS. We agree with the MRC, that production by the Department of Health of clear guidelines on funding by them for the medical research community would be welcome.

THE NHS AND MEDICAL RESEARCH

13. The importance of the NHS as a test-bed for medical research is vital. By virtue of its national coverage, the NHS is able to provide a broad, well documented database of patient information and a wide range of patients for research purposes. This is unobtainable in most other countries where information is held by a large number of individual doctors with no incentive to collaborate.

14. The MRC receives its grant-in-aid from OST. The MRC's mission is to promote and support high quality basic and strategic research in all branches of biomedical science with the aim of maintaining and improving human health. To fulfil its mission, it is essential, therefore, that the MRC is able to have access to the NHS to conduct basic, clinical and health services research.

15. Excellent collaboration between the MRC and the Department of Health, and between the MRC and the NHS has developed since the formation of the NHS nearly 50 years ago. During this time, important research and major clinical trials have taken place. This relationship has created an environment which has led to the discoveries of the structure of DNA, monoclonal antibodies and haemoglobin. Recent breakthroughs in medical science, including the discovery of the gene for Huntington's disease, provide further evidence of the essential and successful relationship between the MRC and the NHS.

16. A concordat exists between the MRC and the Health Departments which provides a framework for the systematic development, review and evaluation of their respective needs, priorities, activities and progress. The concordat provides a mechanism through which any problems arising from ongoing or proposed MRC research programmes can be considered. OST agrees that the MRC will need to enter into discussions with the Health Departments to ensure that the concordat takes account of any changes resulting from the Culyer Report.

17. OST welcomes the proposed Department of Health National Forum as an additional mechanism for coordinating research in the NHS. OST membership of the National Forum will provide an important link with the implementation of the Technology Foresight Programme and the annual Forward Look of Government-funded science, engineering and technology. The MRC, the Economic and Social Research Council (ESRC), the Biotechnology and Biological Sciences Research Council (BBSRC), and the Engineering and Physical Sciences Research Council (EPSRC) will also be represented.

18. OST welcomes the inclusion of the MRC in the membership of the revised Central Research and Development Committee (CRDC) which will now advise the NHS on how best to invest its R&D funds.

FUNDING OF MEDICAL RESEARCH

19. Through its grant-in-aid, OST provides funding to the MRC. In 1995–96 this will amount to £277.8 million. Since 1979 the funding for the MRC has grown by almost 40 per cent in real terms.

20. The MRC is responsible for the allocation of these funds through its institutes and units, and project and programme grants. All proposals received are subject to a strict peer-review process and those of the highest quality are funded.

21. The medical charities are major funders of medical research in Britain. In 1993–94 they provided research funds of £317 million. Unlike the MRC, whose mission encompasses research into all aspects of human health, most medical charities concentrate on one specific aspect. There is excellent co-operation between the MRC and the medical charities to ensure that their research programmes are complementary. The OST welcomes the major input that the medical charities provide to medical research in Britain. OST works closely with a number of these charities. The Chief Scientific Adviser has regular contact with, for example, the Wellcome Trust.

22. The location of the European Bioinformatics Institute (EBI) at Cambridge is a good example of collaboration with the medical charities. OST played a major role, together with the MRC and the Wellcome Trust, in bringing the EBI to the UK. Hinxton Hall, near Cambridge, is now one of the foremost genome research parks in Europe.

23. OST believes that it is timely to review the service increment for teaching and research (SIFTR)—the mechanism by which the Department of Health provides funding to those hospitals which undertake undergraduate teaching and research and who thereby incur additional expenses. OST agrees that: there is a considerable funding shortfall; there is no procedure in place to ensure that the funding received is used for its designated purpose; lack of service support for research into primary care creates difficulties; and, that those non-teaching hospitals which undertake research do not currently receive SIFTR. OST therefore welcomes the proposals in the Culyer Report (3.28, 3.46, 3.71) to consider these issues.

24. OST welcomes the Secretary of State for Health's recent announcements of increased funding for research³ and the Department of Health's target commitment of increasing its R&D spend to 1.5 per cent of the total NHS budget.

HUMAN RESOURCES

25. One of the strengths of the medical research community in Britain is the number of research scientists with both medical and scientific qualifications. This is resulting in significant brain gain to Britain. Britain's reputation for basic science, complemented by the provision of an excellent clinical environment for research through the NHS, will continue to ensure that we attract world class medical researchers.

26. Care will be needed in the introduction of the new training grade in the NHS, as recommended in the report "Hospital Doctors: Training for the Future", to ensure that this has no detrimental effect on the number and quality of medical researchers with dual qualifications. Close monitoring of training by clinical deans will be essential if the high standard of medical research scientists is to be maintained.

HEALTH CARE TECHNOLOGY

27. OST is considering the future of health care technologies as part of the Technology Foresight Programme. The Health and Life Sciences Panel, which includes Department of Health membership, covers a wide range of markets, social needs and technologies, including: pharmaceuticals, diagnostics, general medical and veterinary equipment and supplies, non-medical applications of biosciences, medical procedures, health promotion and nutrition, management of health care, production of improved plant and animal strains, and biotechnology in manufacturing. The first Foresight report is due to be published in May, with individual panel reports becoming available before that. The funders of medical research, including the MRC, Department of Health and the NHS, will take account of the Foresight results in planning their research strategies.

28. The results of the Foresight Programme will be reflected in the 1995 annual Forward Look of Government funded science, engineering and technology, also due to be published in May.

29. OST welcomes the Department of Health's intention to set up a new programme in Medical Technologies under the LINK initiative (for which OST has lead responsibility). The MEDLINK programme will promote collaboration between the medical devices industry and research base organisations through the provision of grants of up to 50 per cent for collaborative R&D projects. The LINK initiative is currently under review and there are plans to re-launch it shortly.

CONCLUSION

30. OST will continue to work with the Department of Health and the MRC in implementing the Culyer Report, and help to ensure that the quality of medical research is maintained and improved alongside NHS reforms.

31. Future strategies for medical research will be informed by the Technology Foresight Programme, the annual Forward Look and the Department of Health's creation of a new National Forum to bring together the major health related research funders to provide advice to the NHS and the Government.

2 February 1995

Evidence from the Royal Academy of Engineering

The Royal Academy of Engineering is the United Kingdom's independent self-governing body of professional engineers of all disciplines. The Academy's objectives are the pursuit, encouragement and maintenance of excellence in the whole field of engineering in order to promote the advancement of the science, art and practice of engineering for the benefit of the public. By recognising Britain's most distinguished engineers The Academy aims to take advantage of their wealth of engineering knowledge and

³ The Secretary of State for Health announced on 22 November 1994 an additional £40 million for SIFTR, and on 15 December 1994 an extra £8 million to be made available in 1995-96 for research commissioned by the NHS.

experience. The interdisciplinary character of The Academy's membership provides a unique breadth of engineering experience with which to further all forms of engineering.

In order to overcome traditional barriers, The Academy promotes a multi-disciplinary approach to demonstrate the interdependence of different areas of expertise in the effective use of modern technology and engineering. Emphasis is also placed on the importance of well-informed communication between engineers, Government, research establishments, industry, public services and academia.

This evidence represents a collation of personal views from Fellows of the Royal Academy of Engineering. It cannot reflect the views of all contributing Fellows nor those of The Academy as a whole. It may, however, be regarded as representative.

1. *What is your assessment of the NHS R&D Strategy? You may wish to comment on the centrally-commissioned programme, the role of the Regional Research Committees and Regional Directors of R&D, health technology assessment, the Cochrane and York Centres, the Research Liaison Committees or any other aspect of the Strategy. Do you have advice for the NHS Director of R&D as he takes the Strategy forward?*

1.1 The Strategy lays the foundation for a change in the culture of the health care system in the UK. It is designed to enable medical practice to be based on the results of research, rather than on tradition and fashion. The emphasis of the R&D Strategy is on health services research, as distinct from biomedical research; this is completely proper, since it is only through the evaluation of health technology that the efficacy of medical procedures and interventions can be measured. The institution of the centrally-commissioned programme, the setting up of Regional Research Committees and the appointment of Regional Directors of R&D, the work on health technology assessment and the establishment of the Cochrane and York centres have been most successful initiatives; they have provided the momentum that the Strategy required in order to become effective.

1.2 The concept of the R&D Strategy is commended. However, with the emphasis on health services research and a heavy weighting on commissioned research and development, and clinical evaluation, the Strategy has drawn attention away from basic and applied biomedical research. It is indisputable that only the results of biomedical research can lead to change in health technology and, consequently, to the improvement in the health of the nation. This is not to diminish the vital role of health services research in determining what new technologies should be adopted and the optimal allocation of resources for health care delivery. Nevertheless, the diversion of attention from biomedical research inevitably raises the possibility of its neglect by policy-makers, and of the diminution of resources available for its prosecution.

1.3 Traditionally, many Regional locally-organised research schemes provided funding for biomedical research, often propelling newcomers to the research field into a lifetime of productive research activity. It is considered that funding for health services research ought not to be obtained by diverting resources from this traditional area, but by the provision of new funds. The levy on purchasers is not universally welcome and some care will need to be taken to ensure pure research is not neglected in favour of development and evaluation. The implementation of a more centralised structure and a more direct role in managing R&D funds are welcomed.

1.4 In seeking to optimise the diffusion of new surveillance, monitoring, diagnostic and therapeutic techniques, the NHS Director of R&D has a formidable problem in respect of rapidly-changing technologies. Inevitably, his primary (and perhaps sole) concern is to optimise the use of NHS resources. This may not be coincident with the optimisation of the UK's competitive position in the global market for medical equipment (or, presumably, for pharmaceuticals and diagnostics). The NHS Director of R&D is urged to be mindful of the need not to inhibit technological innovation in the development of new medical technologies.

1.5 The Academy has a particular interest in medical engineering, recently having published a review of the subject and having set up the UK Focus for Biomedical Engineering which brings together representatives of the principal engineering, scientific and medical institutions concerned with the subject. It has been noted, with some disappointment, that, although a biomedical technology research liaison committee (with membership including the DH, SOHHD, DTI, MRC, the former SERC, the ESRC, the Association of British Healthcare Industries and AMRC) was established, it met only twice in 1992. The Academy is most anxious that the potential contribution of medical engineering in the NHS should not be neglected and keenly hopes that the NHS Director of R&D will give careful consideration to this.

2. *What is your response to the Culyer report on "Supporting Research and Development in the NHS" (HMSO, September 1994)? Do you have suggestions, or concerns, as to how it might be implemented? You may wish to comment on service support for curiosity-driven research in NHS hospitals; tertiary referrals in the internal market; the consequences for clinical trials; or any other issues raised by the report.*

2.1 This report is considered to be a model of clarity and good sense. The recommendations are incisive. The Government's announcement on 15 December 1994, that it was intended to implement the broad thrust of the recommendations, is welcomed. In many NHS Trust hospitals, there are departments of medical physics and bioengineering (or departments with different names but similar functions) in which curiosity-driven research is a vigorous activity. Moreover, these departments form an essential part of the infrastructure of the hospital which makes it possible for high-quality R&D work to be undertaken by

clinicians and non-medical staff alike. The fact that the Culyer report specifically recognises this, and recommends a mechanism for the continuation of the funding that makes it possible, is warmly welcomed. Indeed, we believe that the requirement to declare R&D activity as a condition of receiving funding, and the proposal that a formalised assessment by research ratings should be adopted, will result in an overall improvement of the quality of the R&D work conducted in NHS Trust hospitals. Nevertheless, The Academy is concerned lest the career structure of medical engineers (and others in the clinical scientist grouping) may be threatened by a possible failure, on the part of NHS Trust hospital managers, to appreciate the strategic importance of nurturing the engineering (and science) base. Moreover, there is a risk of instability during the transitional period between the current system of funding and the introduction of the separate funding stream for NHS R&D.

2.2 The new funding system and Health Service reforms could well bring about two unwelcome effects. If tertiary referrals are largely outmoded there would appear to be a pressing need for a central medical centre of ultimate resource, to tackle the near impossible cases and medical issues. The USA has found that it needs one—and NIH is the result. There is a risk in the UK that a group of difficult patients will be created, too expensive for any Trust to treat, and with no home at all. Secondly, although the new assessment of research centres, similar to that of the HEFCE, is sensible in principle, the mechanisms are a serious burden on institutions, many of whom are unconvinced by the apparent criteria.

2.3 There is also a view that the UK needs a shift in balance towards “health” research as distinct from “medical” research, and the needs are greatest in the primary health care area. This is one area in which the concept of NHS R&D does not sit uncomfortably in the purchaser-provider context and it appears that local research funding is perhaps marginally less at risk for R&D that enhances “care in the community”.

3. *Do you identify additional challenges or opportunities for UK medical research which neither the NHS Strategy nor the Culyer report addresses?*

3.1 This question provoked the greatest comment and concern from Fellows. In question 1, reference was made to the potential of the UK medical equipment industry to contribute to the well-being of the economic health of the nation. It is suggested that serious consideration should be given to exploiting this opportunity which, it has regrettably to be admitted, has been neglected during the last 25 years. As a consequence the UK medical equipment industry has withered, although the UK has been fruitful as the birthplace of new technologies which have been exploited abroad. The Academy hopes to have a catalytic role in such a change in the nation's prosperity.

3.2 In the field of NHS R&D, medical engineering is frequently perceived simply as a provider of tools to enable R&D to be performed in easily-recognised areas such as molecular biology or the neurosciences. Although this is understandable, it is true only to the extent that the results of medical engineering R&D are often overarching or underpinning technologies, such as those for imaging or physiological measurement. The medical engineering R&D which results in these innovations should be recognised as an R&D discipline in its own right. Happily, the EPSRC appears to have done this, as it is in the process of setting up a Medical Engineering College. There should be corresponding recognition of the importance and identity of medical engineering in the NHS R&D Strategy.

3.3 The proposed NHS system for research funding restricts prospects to narrow bands. There is no obvious way in which:

- an imaging system could be invented and developed
- a robotical surgical unit could be designed and developed
- a new prostheses could be created
- fundamental materials research could be performed for implants

With bioengineering funding from the Research Council being split between EPSRC and MRC and with uncertain support in the NHS R&D system, any engineering based developments will be difficult to manage. Bioengineering does not have the strong pharmaceutical industry supporting drugs, nor the MRC and Wellcome Trust support for molecular biology.

3.4 Three particular research topics, essentially methodological, are commended for initiation or strengthening in the UK.

3.4.1 The need for knowledge-based indicators of health status and associated socioeconomic factors.

Much important information about the health of the community exists as semantic knowledge rather than as quantitative data or even qualitative information. (The same is true of complex matters like organisational and system behaviour.) The techniques of cognitive science and computational logic offer an opportunity to capture and make use of semantic information in a formal and rigorous way. Application areas occur in the development of health-related and other socioeconomic indicators. One important issue concerns medical audit and the role of socioeconomic factors in influencing the medical needs of individual patients, the specific intensity of their condition and the matter and rate with which they respond to particular types of treatment. In brief, it is suspected that comparisons of performance as between different centres, and any specialist procedures they utilise, cannot be fully informative without regard to the socioeconomic characteristics of the pool of patients they serve. Resolution of this issue would be of benefit both to medical practice and to managerial aspects of health care provision.

Developing and using this technology, it should also be possible formally to study the interactions between “health” and activity; in other sectors of the economy. This would offer a better basis than at present for the allocation of funds at national level. The consequences, throughout the economy of various choices, could be more clearly identified, and the health consequences of various industrial or other developments recognised. The present strategy cannot be seen to recognise the desirability of working towards a rigorous basis for allocation of funds to the national benefit, rather than according to short-term political priorities. It is likely to need long-term effort but it should serve long-term needs in the health sector.

3.4.2 BEHAVIORAL MODELS OF ORGANISATIONS

The ways in which organisations “behave” in various situations is a function of many factors that include the organisational structure and dynamics, and the nature of interactions between the personnel required to operate the system. Human factors are often dominant in determining organisational performance, and the development of models to allow diagnostic study of poorly performing organisations, and the testing of various strategies designed to achieve specific targets, will be facilitated by the availability of knowledge based indicators.

This is one aspect of wider information needs. The UK is well served by its national information sources, although there is always a case for new data. However, it is not always evident that the importance of acquiring the essential information is recognised prior to embarking on the managerial adjustments that are now so much a part of the UK health scene. The recent discussion document on a new strategy for the National Blood Authority is a clear illustration of the failure to identify the essential information needs that are prerequisite to the formation of a strategy, or to explore the likely costs and consequences of the proposed strategy.

The understanding of how to use information in developing a strategy is hardly R&D, but it is an important adjunct to organisational system design and to understanding its behaviour; the management-driven climate in the UK at present needs such support.

3.4.3 TRANSFER OF TECHNOLOGY INTO THE HEALTH SERVICE

The Culyer Report raises the problem of implementing R&D findings. It is considered unduly hopeful to expect much “help and support in this area” even from the source cited (Regional Directors of R&D); the matter is complex.

Implementing R&D results has much in common with transfer of technology. The transfer of technology has commonly been an *ad hoc* process involving a number of parties: a source (“donor”), keen or willing to be persuaded, to release the technology for use by another group, organisation or country; certain parties in the “host” group that are keen on the transfer; other parties who are required to implement the transferred technology, but who may or may not be anxious to do so, because of apprehension about consequences on themselves and their work, uncertainty about adequate access to advice and support, and potential conflict with cultural factors within the group, organisation or country. It is hardly surprising that there have been many failures in the transfer of industrial or health technology to developing countries, and many examples in the UK in which damaging complexities, or even failures, have been caused unnecessarily in the related but simpler task of introducing new technology (especially information technology) into commercial organisations. It is doubtful if the health service is different.

Further, even when no new technology is being implemented, the progressive growth of a familiar but rapidly developing technology in health care delivery can produce comparable difficulties. For example, an Expert Group on “Alarms on medical devices” for the DoH Medical Devices Agency recently found that many hospitals or units making extensive and increasing use of clinical monitoring devices lacked various important procedures and practices. But these might well be in place had electronic monitoring technology been introduced as something brand new. There were *inter alia* a deficiency of formal arrangements for training staff in the use of devices; of prescribed procedures for ensuring that devices were correctly re-enabled and alarm levels re-set after disconnection for legitimate reasons; and of explicit arrangements for regular maintenance. Most users accepted that these measures should have been in place: no one had recognised the omission during the steady growth in usage of such devices.

More generally, technology “transfer” or implementation practices could benefit from an examination of the whole process *ab initio* so that the crucial principles can be accommodated as part of the process. Again, this type of investigation could draw upon the same kind of developments in computational logic and cognitive science mentioned above. Successful advances here could become tactically important in the health sector: especially in planning for the successful transfer and use of technology in the provision of health care

delivery. A well thought-out strategic plan for the use of technology in health care would be of considerable value to those responsible for advising on implementation. This is not R&D but it is an important adjunct; such matters should not be overlooked.

Evidence from the Council of Deans of Medical Schools

At the time the Council of Deans representatives gave evidence to the Select Committee the Chairman indicated that he would be quite willing to receive further representations from the CDMS. There are four points which we should like to emphasise when the Select Committee comes to sum up its deliberations.

1. The steady erosion of unit of resource for clinical academic medicine since the mid-1980's, and the prospect of a further reduction in the current year has impaired the Medical Schools' abilities to support clinical academic research. Demands of service, which take up 60 per cent of a clinical academic's time, means that reduction of resources is often at the expense of research time and research infrastructure. There is a need to impress on HEFCE that imposing efficiency gains on the clinical academic disciplines has quite different consequences from those in other subject areas in Universities.
2. The direct NHS support for clinical academic staff is a crucial element of all Medical Schools. These staff are reported for statistical purposes as being wholly University funded but their pay is NHS money funnelled through the Medical Schools. We fear that random decisions of NHS purchasers may threaten this support, which in some Medical Schools represents more than 40 per cent of the clinical academic staff and particularly in those Cinderella disciplines in the NHS which the Department of Health wishes to see develop.
3. The introduction of the unified training grade in the post-Calman era will reduce the number of junior doctors on academic units and also reduce their research time because they will be following a more structured educational programme. It is essential that funds are found either from NHS or HEFCE sources to match the increase of NHS consultants with additional senior lecturer posts so that the staffing levels on clinical academic units can be maintained.
4. The recommendation from SIFTAG seems likely to include a clinical placement fee of 20 per cent and a facility payment of 80 per cent. The facility payment will overlap with the Culyer infrastructure payment in main University Hospitals. There is an urgent need for liaison between the NHS R&D funding stream and the SIFT funding stream, with University representation on both, to ensure that infrastructure support of the main research base teaching hospitals is maintained.

Colin T Dollery
Past Chairman

Professor Peter Richards
Chairman

Professor Frank Harris
Executive Secretary

6 April 1995

Evidence from the Royal Society

1. We welcome the opportunity to submit evidence to this timely inquiry. Our evidence takes the form of a critique of the Culyer Report, with some general comments leading into a discussion of the Report's main recommendations. We share the concern expressed in the Culyer Report over the future of medical research in the face of the NHS reforms. There is an urgent need to establish a means of securing the medical research base in the UK.

2. The Culyer Report as a whole is a step in the right direction. The following general considerations underpin our detailed analysis of the report.

- The implicit definitions of "research" used in different sections are confusing. Medical research involves a number of linked but separate endeavours. There is little or no analysis in the report of the individual needs of non-targeted research, of clinical research or, for example, of multi-centre clinical trials. The full range of endeavours needs to be supported.
- The report's recognition that medical research should not be driven solely or directly by purchasers' perceptions of their own needs is important.

- The flexibility of a pluralistic system of project funding is vital to the long-term well-being of the overall portfolio of medical research.
 - Monitoring and evaluating the use of funds allocated for broad research objectives are central to the effective management of NHS R&D. Both are difficult. The distribution of research infrastructure support should take account of the distribution of project activity.
 - The report's recognition that individual institutions need a degree of long-term funding stability is crucial.
 - The lack of effective discussion of the methods of implementing the main recommendations lessens the value of the report.
3. We warmly support the recommendation (para 3.6) to establish a national forum for exchanging information about the research strategies of the national bodies that sponsor or support R&D in the NHS.
4. We are not convinced that the Central Research and Development Committee would be able to discharge effectively the new role proposed for it (para 3.13).
5. We support the recommendations concerning the roles of Regional Directors of R&D (para 3.24).
6. We support the proposal to define explicitly and in some detail the use of NHS funds related to R&D (para 3.25) in principle. This will serve the valuable function of publicly clarifying NHS research priorities. Care will be needed to ensure that the proposal is implemented in a way that does not create unnecessary hurdles and delays to the allocation of funds.
7. The proposals concerning funding streams (paras 3.28, 3.30, 3.38) raise important issues. The balance of advantage between different funding mechanisms is a complex issue. For example, a single funding source for the clinical support of research would greatly simplify nationwide projects; but we are also conscious of the value of plurality in research funding generally, reducing the scope for a single viewpoint to dominate the agenda. We believe strongly that the R component of SIFTR must be maintained as a distinct element of the total funding strategy; without it, it would be impossible for research institutions to undertake any sort of long-term planning. The R component of SIFTR should be distributed according to research capability rather than in proportion to undergraduate student numbers. Moreover, this element of funding must be accounted for in a way that minimises administrative costs. We warmly support the recommendation that R&D funding be drawn from top-slicing the budgets of health care purchasers; individual purchasers cannot be expected voluntarily to pay for research aimed at generalised, long-term benefits.
8. We accept the three-fold classification of NHS R&D-related funding (para 3.46), on the understanding that category (a) refers solely to projects and programmes funded by the NHS under the Peckham Programme. Category (c)—core institutional costs—needs a higher profile; it must be recognised that it will be by far the largest component.
9. We accept the need for formal evaluation of research performance, at both individual and institutional level. We are also very conscious of the costs of evaluation—particularly in terms of the individual's or institution's time—and of the potential for overlapping evaluations being carried out by a multiplicity of funding agencies with different agendas and timetables. The HEFCE approach, after several iterations, now commands a fair measure of support in the research community generally. Reviews should be carried out at intervals of not less than five years. The target that new criteria for research facilities funding, and interim costing techniques for research, be developed for use during 1995–96 (para 3.62) is unrealistic.
10. We support the recommendation (para 3.71) that funds for service support as “well as for the direct costs of R&D be made accessible to professionals working in primary and community health care settings”.

31 January 1995

Evidence from the Society for Research in Rehabilitation

ABOUT THE SOCIETY

The Society for Research in Rehabilitation is a flourishing, multi-professional, group which was founded in 1978. The main objective is to promote the study of all aspects of rehabilitation of disabled people. The Society, which has four hundred members from the disciplines of nursing, occupational therapy, physiotherapy, speech and language therapy, medicine, psychology, engineering, sociology and physiology, meets twice a year with the aims of

1. fostering a climate in which health professionals and others interested in rehabilitation can extend their skills in research related to their field;
2. to raise the profile of research in rehabilitation and to promote the initiation and completion of relevant, well designed studies;

3. to encourage the general dissemination of findings, from such studies, to provide a forum specifically for the purpose.

The Society welcomed the new vigorous approach towards research signalled by Professor Peckham. However, we have been disappointed in some areas and would like to draw your attention to these.

(a) *Communication*

Unfortunately, the communication between the Central Research and Development Committee, and professions other than doctors and nurses, has caused a great deal of consternation. Frequently these other professions seem to be excluded from the channels of dissemination. The society feels that it has actively tried to assist the Central Research and Development Committee by keeping them informed of our activities, assisting with specific projects and notifying the Committee of various meetings.

We have also drawn attention, on several occasions, to the difficulties experienced and possible ways of overcoming the problems of communication. An example of this is the fact that many tenders for research are advertised in journals not usually accessed by others than those in the nursing and medical professions.

We do accept that there is an increased statement of intention to include these professions. We were delighted to be supported and encouraged to develop the Position Statement on Research and Development in Occupational Therapy, Physiotherapy and Speech and Language Therapy which the Committee has received. However there has been disappointment that so little has followed the prestigious launch.

(b) *Conducting Research within the New NHS*

There are many challenges to conducting research given the changes in the NHS. Some of these are as follows:—

- difficulty in co-ordinating multi centre trials given the reduction in collaboration between trusts;
- the concern by trusts regarding the true cost of infra-structure, related to research, causing them to withdraw support or encouragement for research in various sites;
- the reduction of flexibility in job descriptions which formerly included an element related to research as trusts require clinicians, particularly therapists, to be full-time on clinical duties and do not leave scope for any time related to research;
- trusts are debating issues related to intellectual property rights, etc.

(c) *Careers within the NHS*

I should like to draw the attention of their Lordships to the particular problem of members of the therapy professions developing research careers within the NHS. If I may be presumptuous, I would like to cite my own particular case as an example.

Prior to the NHS reforms, I was a District Therapy Manager, with responsibility for clinical work, management of the district service and research within the clinical area. In many trusts the district management posts for therapists have disappeared and therapists have been deployed in a different way. Many of the more senior grades of the profession have been done away with and it is now impossible for me to get a senior position within my profession with a research and clinical component.

I now work in an independently funded unit and have a three month contract. If I am unable to attract research grants, neither I, my team, nor the Unit, can remain open. The whole situation is extraordinarily tenuous and is not unusual for many therapists. We may have the opportunity of going into educational posts but this does not close the gap between research and the NHS clinical delivery.

A related issue is regarding therapists spending some time in clinically based research. Unfortunately the pressures upon them are so great, and job descriptions have now been changed, that they are discouraged from participating in any research activities.

We are aware of some therapists not admitting to their Ph.D status on their CV's because this has become a disadvantage to them in gaining employment within the NHS.

(d) *Research in the NHS—Methodologies*

If research is to affect NHS delivery of services, it is essential that it is not just confined to the fields of nursing and medicine. In addition, it is important that methodologies which are appropriate for different questions associated with different professions, become respected and acknowledged.

Certain research methodologies that are commonly used within medical research are not appropriate for research into some therapy issues. Unfortunately, there is frequently a general lack of appreciation of the different research designs that facilitate improved knowledge in some social aspects of therapy.

The situation could be improved by ensuring that Regional Research and Development Directorates have an active input from a broader range of disciplines. Additionally, we would suggest the Central Research and Development Committee should broaden its membership.

Thank you for allowing us to present these views at this late stage.

Dr Pam Enderby
President

13 March 1995

Evidence from the South Sefton Research Ethics Committee

My Committee is very concerned that we should continue to facilitate medical research within a sound ethical context. Since the NHS reforms new investigators have appeared with fields of enquiry into healthcare provision and efficacy of therapeutic interventions in the most broad sense. Some of the approaches have been rather novel compared with traditional medical trials and many have come from investigators of limited experience. This has posed many unexpected and challenging questions for the local research ethics committees.

As Chairman of my Committee, I am always aware that my Members are unpaid volunteers. They spend considerable amounts of their own time serving the community by addressing the conflict of interests that can arise when scientific medical research deals directly with individual subjects and the community at large. It is important that Committees are made up of a broad spectrum of experience and views. To retain public confidence we feel that independent lay members are essential constituents. By the nature of the Committee's work, Members see large numbers of research protocols. Through training and experience they become well placed to decide which submissions are poor and which acceptable. Investigators tend to be single minded individuals or groups with vested interests, and as such they can lose sight of a wider view. For this reason it is not at all unusual for Research Ethics Committees to reject submissions or at least demand substantial modifications on the basis of unacceptably poor scientific validity and hence ethical acceptability.

The Department of Health has published "*Draft Guidance on the Confidentiality, Use and Disclosure of Personal Health Information* (1994)" of which Local Ethical Committees are aware. Committees have also been aware of a proposed Private Member's Bill of a similar title which was very widely researched, with consultation involving the Royal Colleges, Healthcare Profession Representative Bodies and Research Ethics Committees. We have in addition had our attention drawn to concerns raised in medical journals regarding confidentiality. While my Committee has observed an obvious rise in the number of groups wishing to research healthcare provision, this has also involved investigators who are often new to this sort of research. In many cases they have little or no concept of the traditional ideas of what has come to be regarded as the reasonable balance between the interests of the individual versus the community at large.

Part of the function of Local Research Ethics Committees is to be aware of the research standards of the investigators locally because there is an obligation to monitor the performance of research which has been approved. Most Committees are however, totally unable to carry out the latter function because they are provided with no resources to make this possible. The "new healthcare researchers" are often not trained healthcare professionals. While this may not be unreasonable as far as performance of the work involved is concerned, there is a difference regarding responsibility. The professional healthcare worker needs to observe standards of practice relative to the professional body which is entrusted with questions of discipline and responsible behaviour. If they do behave irresponsibly, there is always the threat that, in the worse case, they may risk loss of their professional status. Where no such background is evident Research Ethics Committees would be wrong not to take this into account when considering questions of adequate confidentiality for healthcare record supervision etc.

While there are many Guidelines produced to assist Research Ethics Committees in their deliberations, there are few rules. The Guidelines can contradict one another. (For example "*Independent ethical review of studies involving personal medical records*", Journal of the Royal College of Physicians 1994, vol 28, pp 439-443.) The pressures on Committees from investigators, outside agencies (eg pharmaceutical companies) and management in general are not inconsiderable. As Chairman, I often feel that everyone who interacts with my Committee wants to dictate how it should be run. There are financial consequences of medical research and these have increased with the investigation of the provision of healthcare. The bodies from whom management have commissioned local healthcare provision studies have, in certain cases, made it abundantly clear that financial assistance associated with such enquiries will go to other hospitals if the particular Local Research Ethics Committee is not compliant.

The Department of Health has been aware of concerns about different working practices and ethical criteria adopted by LRECs. It is my experience that Research Ethics Committees have never been slow to respond to offers of instruction or assistance. Seeking advice is a common activity. At the same time what advice is received depends on who is asked and there are no recognised authorities for almost all the areas which cause concern. The Department of Health's recent informative courses for Committees based around the "Standards for Local Research Ethics Committees" were well received.

Many workers in the NHS, perhaps with more encouragement than previously, wish to investigate the effect of different forms of medical intervention. There is a perception in some quarters that *audit* and *research* are different and to an extent mutually exclusive in order to "close the loop" in medical audit. The results of an intervention are measured, the intervention is revised and the results of the change are measured again. Some workers regard appraisal of such changes as clinical research and seek oversight and approval from their LREC, while others assert this is clinical audit and that no such oversight is necessary. We feel that the latter approach derives patients of important safeguards and could allow researchers unlimited freedom to pursue research of dubious quality which may also be ethically suspect. There is also a perception that the audit pathway is an easy way of facilitating progress and that avoiding ethical review may therefore have advantages for investigators. It would appear to be the case that national bodies with an interest in researching healthcare questions do not appear immune to exploiting this "grey area".

It occurs to Members of my Committee that there is a way forward that the Department of Health does not appear to have considered. We suggest that a systematic national audit of the performance of LRECs is appropriate. This should have the advantage of understanding differences between committees' ethical reviews and also lead to a clearer understanding of what might come to be regarded as "ethical precedent". This sort of information might then be held by a national office to which LRECs could turn for advice as appropriate.

Dr P Charters
Chairman

23 March 1995

Evidence from the Standing Committee on Postgraduate Medical and Dental Education

BACKGROUND

The Standing Committee on Postgraduate Medical and Dental Education (SCOPME) was set up by the Secretary of State for Health and Social Security in 1988 as the successor to the Council for Postgraduate Medical Education in England and Wales (CPME). Prior to 1993 SCOPME was known as the Standing Committee on Postgraduate Medical Education.

The purpose of this document is to outline the central purpose and aims of the Committee and how its affairs should be managed. This document deliberately avoids going into unnecessary procedural detail as certain procedures are of necessity fluid and are best left to detailed discussion with the Medical Education, Training and Staffing Division of the Department of Health which is the departmental liaison point for the Committee.

1992 REVIEW OF SCOPME

In accordance with Cabinet Office and Treasury guidance, SCOPME was subject to a review by the Director of Health Care in 1992.

The review noted that the objective of safeguarding and developing medical and dental education had to be driven forward in an increasingly complex environment, leading to a natural evolution in the Committee's rôle.

Against this background the review concluded that:

- the case for the provision of independent advice to the Secretary of State is stronger than ever;
- no alternative has been identified which could match the SCOPME concept in terms of demonstrable independence and value for money.

AUTHORITY

The Standing Committee on Postgraduate Medical and Dental Education has the status of a non-departmental public body and was set up in 1988 by the Secretary of State for Health under sections 1 and 2(b) of the National Health Service Act 1977.

TITLE

The organisation is known as “The Standing Committee on Postgraduate Medical and Dental Education” (abbreviated to SCOPME).

TERMS OF REFERENCE

The revised terms of reference approved by the Secretary of State following the 1992 review of SCOPME are:

“To advise the Secretary of State on the delivery of postgraduate and continuing medical and dental education, taking into account both the standards promulgated by professional and educational bodies and the potential difficulties of reconciling service and training needs; to identify particular problems and to develop realistic solutions to these in consultation with relevant interests and to report regularly.”

OPERATION

The operation of SCOPME will at all times be in accordance with the guidance issued for non-departmental public bodies.

MEMBERSHIP

The Chairman and up to 18 members will be appointed by the Secretary of State on the advice of the Chief Medical Officer and the Chief Dental Officer, following nominations from professional bodies who cover a wide range of professional and service interests. Members will not be appointed as representatives of their nominating bodies but for their personal expertise. All appointments will be unpaid. Recommendations for membership and alternatives will be presented to Ministers whenever membership falls to be renewed.

Details and composition of the membership of SCOPME are given at Annex 1.

OFFICERS

SCOPME will employ a medically-qualified secretary and a small secretariat who will also be responsible for servicing any ad-hoc working parties, for day-to-day management of research and other administrative tasks.

Routine contact with the Department will be between the Chairman or secretariat and officials of the Health Care Directorate—Medical Education, Training and Staffing (HCD-METS) Division; the head of HCD-METS will normally be the Department’s observer on SCOPME. Where appropriate, however, the Chairman will have access to the Chief Medical Officer, the Chief Dental Officer or DH Ministers.

CENTRAL GOVERNMENT AND DEPARTMENTAL POLICIES

SCOPME will at all times act in accordance with Central Government and Departmental policies on Equal Opportunities, Open Government and the Citizens’ and Patients’ Charters.

SCOPME’s Submission to the House of Lords Select Committee Enquiry into Medical Research and the NHS Reforms

ABOUT SCOPME

1. SCOPME welcomes the House of Lords Select Committee enquiry into medical research and the NHS reforms as an opportunity for SCOPME to comment on the implication of the NHS research and development strategy for postgraduate and continuing medical and dental education. The membership of the Committee is given on the next page.

2. SCOPME’s terms of reference are to:

- advise the Secretary of State on the delivery of postgraduate medical and dental education, taking into account both the standards promulgated by professional bodies and the potential difficulties of reconciling service and training needs;
- identify particular problems and to develop realistic solutions to these in consultation with relevant interests;
- report regularly.

3. The Standing Committee is concerned only with postgraduate medical and dental education in England. There are separate Councils for Postgraduate Medical Education in Scotland, Northern Ireland and Wales. Vocational training and continuing education in the General Dental Service is the responsibility of the Committee on Dental Continuing Education and Training (COCET).

4. SCOPME's financial allocation from the Department of Health contains provision for the Committee to commission research into postgraduate medical and dental education, the results of which are needed to inform the Committee's independent advice to the Secretary of State for Health.

MEMBERSHIP OF SCOPME (FEBRUARY 1995)

Members

Professor Dame Barbara Clayton (chairman), Hon. research professor in metabolism, Southampton University.

Dr Trevor Bayley (vice-chairman), Regional postgraduate dean, North West region, Royal Liverpool Hospital, Liverpool.

Dr Deb Bose, General practitioner, Finchfield, West Midlands.

Dr Fiona Caldicott, Medical Director, South Birmingham Mental Health Trust, and President of the Royal College of Psychiatrists.

Dr Colin Coles, Senior Lecturer in Medical Education, Faculty of Medicine, Southampton University.

Miss Constance Fozzard, Consultant obstetrician and gynaecologist, Truro, Cornwall.

Professor John Frame, Postgraduate dental dean, West Midlands region, Birmingham.

Dr Steve Hajioff (doctor in training alternate) General practitioner trainee, Barnet, Hertfordshire.

Mr Bryan Harrison, Formerly regional general manager, North East Thames RHA.

Mrs Celia Ingham Clark, Lecturer in general surgery, Royal Free NHS Trust, London.

Dr Angela Jones, Regional consultant in public health medicine, North Thames region.

Dr Eddie Josse, Regional adviser in general practice, North Thames region, BPMF.

Mrs Rita Lewis, Health policy consultant in public health, Coulsdon, Surrey.

Professor Cedric Prys-Roberts, Professor of Anaesthetics, University of Bristol and President of the Royal College of Anaesthetists.

Mr Stephen Rear, General dental practitioner, Henley on Thames.

Dr Deborah Richardson-Kelly, Associate regional postgraduate dean (human resources) and hon. consultant in public health medicine (medical manpower), North East and Yorkshire region, Newcastle upon Tyne.

Mr David Rule, Regional postgraduate dental dean, Thames regions, BPMF.

Professor Terence E. Stacey, Director of Research and Development, South Thames region.

Mr Roy Wheeldon, Formerly general manager, Walsgrave NHS Trust.

Dr Peter Wilkinson, Consultant physician and Medical Director, Ashford Hospital NHS Trust, Middlesex.

Assessors

for the General Medical Council

Professor Charles George, Dean of Medicine, South General Hospital.

for the General Dental Council

Mr Louis Kramer, General dental practitioner, Southport, Merseyside.

Observers

Dr Graham Buckley, Executive Director, Scottish Council for Postgraduate and Continuing Medical and Dental Education, Edinburgh.

Dr Robert Hangartner, Senior Principal Medical Officer, NHS Executive, Department of Health, Leeds.

Professor Tom Hayes, Postgraduate dean and Secretary, Welsh Council for Postgraduate Medical Education, Cardiff.

Dr Jack McCluggage, Postgraduate dean and Chief Executive, Northern Ireland Council for Postgraduate and Medical Education, Belfast.

GENERAL COMMENTS

6. Although many of the issues covered in the two reports under consideration may be thought to be outside SCOPME's terms of reference, SCOPME considered that the relationship between education and training and the wide scope of research and development is such a close one, that comment on many of the issues raised by SCOPME is legitimate. The terms of reference of the task force chaired by Professor Culyer do not exclude comment about the implications for postgraduate and continuing medical and dental education as Section i. states "[to] take stock of the current situation with regard to the conduct and support of R&D in the NHS, to establish the nature and extent of any problems, and in that light to consider whether it is appropriate to make recommendations;"

7. Education and training, research and development and audit form a triangular relationship that is essential to the further success of the NHS. Education and training should help the acquisition of the critical faculties that are necessary to assess research findings and implement them in clinical practice where appropriate. Audit provides the means for clinicians to evaluate their performance against those set by external bodies and by peers. The results of both audit and research and development should feed into education and training programmes. Much of modern education and training is to do with preparing clinicians to manage change, and change management skills are needed to make the best use of research findings.

8. In a rapidly developing market driven healthcare system both education and training, and research and development can be threatened if appropriate steps are not taken to secure their funding and to ensure that they remain a *high priority* alongside the necessarily shorter term objectives of immediate patient care.

9. SCOPME supports the main thrust of the research and development strategy set out in *Research for Health*. The "Culyer" report *Supporting Research and Development in the NHS* also contains important recommendations for the organisation of R&D, many of which have been accepted by the Government for implementation (press release 15 December 1994). Both documents should make research and development within the NHS a more planned and managed process, with consequent benefit to postgraduate and continuing medical and dental education.

10. SCOPME supports strongly the recommendations in the "Culyer" report for the need to protect investment in R&D. It also supports the view that those who perform R&D should justify their use of resources and be accountable. It agrees that, as more clinical care is delivered in a community setting, it is time to place R&D in the primary and community sectors on an equal footing with the acute sector.

11. SCOPME was disappointed that neither report makes specific reference to:

- the role of research experience in postgraduate medical and dental training and the impact of the "Calman" recommendations on specialist training;
- the need for an education and training strategy to ensure that research findings are implemented efficiently;
- the general inadequacy of "research skills" linked to clinical medicine;
- the need for research into education.

12. The most recent GMC recommendations on undergraduate medical education stress the importance of strengthening the basic science/clinical link. The new arrangements for postgraduate training following the recommendations of the "Calman" working group may have a major impact on the availability of research experience to doctors and dentists in hospital training. Potentially, this could have a significant effect on participation of the training grades in research projects and their acquiring an awareness for the need for a strong research base for the NHS. These issues are likely to be considered in greater detail in a report for consultation expected from the NHS Executive during 1995 on training in academic and research medicine.

COMMENTS IN RESPONSE TO THE SELECT COMMITTEE'S THREE QUESTIONS

1. *What is your assessment of the NHS R&D strategy? You may wish to comment on the centrally-commissioned programme, the role of the Regional Research Committees and the Regional Directors of R&D, health technology assessment, the Cochrane and York Centres, the Research Liaison Committees or any other aspects of the strategy. Do you have advice for the NHS Director of R&D as he takes the Strategy forward?*

13. SCOPME considers that the concept of a central research strategy for the NHS was an important step forward, and a clear unambiguous timetable needs to be established. Previous arrangements based largely on regionally organised R&D and local and personal initiatives produced many important results but insufficient attention was paid to health care objectives of national importance, the needs of the non-acute health care sector, and the sharing of information to minimise unnecessary duplication of effort. Implementation of the strategy as set out in *Research for Health* will be helped by the national register for research projects, the Cochrane Centre and better interaction between the MRC, the medical research charities and the NHS. In a situation of finite resources, increased accountability for, and transparency of, public expenditure and increasing health needs, such improvements are greatly welcomed. There is, however, an absence in the "Culyer" Report of clear statements about the size and pattern of expenditure on R&D since 1991, and

transparency in this area too is needed especially if targets for overall expenditure are to be monitored and met within an agreed timetable.

14. SCOPME considers that both strategically driven R&D and curiosity-led research have important parts to play. It is perhaps too early to know which approach is likely to benefit the nation's health most. Careful evaluation will have to be undertaken over a long period.

15. The education and training agenda arising out of any national strategy for improving health (e.g. as set out in the Government's White Paper *The Health of the Nation*) is huge but the educational and training implications are not considered in depth in the two reports under consideration. Much of education and training still rests on didacticism and individual expert opinion. The wider adoption by all health professionals of personal responsibility for learner-centred education, critical appraisal and evidence-based practice, as recommended by the General Medical and Dental Councils, the King's Fund Centre, SCOPME and others, should assist the implementation of R&D but much work still needs to be done to bring this about.

16. As yet, the R&D strategy has not achieved the stated objective of effective transfer of information (page 21, col.3). Research findings tend to remain within the sphere of those with an active interest in research in particular areas and their wider dissemination is not very effective. SCOPME is concerned that the work of the Cochrane Collaboration, for example, is insufficiently known and its findings insufficiently applied. Ways also need to be found of translating R&D findings so that they can be used by purchasers and providers to meet identified health needs.

17. Further, information alone is not sufficient. All parts of the medical and dental educational curricula suffer from information overload. The overall aim should be to make clinicians more critical of the information they are given and how they themselves practise. A full understanding of both educational principles and the system for postgraduate and continuing medical and dental education is therefore needed to make implementation strategies successful. There are both opportunities and barriers to bringing about change in clinical practice, and research into these is necessary as part of an implementation strategy. SCOPME supports strongly the centrally commissioned research into implementation and the setting up of R&D education and training groups at regional level. SCOPME advocates that these developments should be given high priority, particularly during the early years of the R&D strategy.

18. Research into education itself is an important part of implementing an effective R&D strategy. Account must be taken of the ways in which doctors, dentists and other health professionals learn and work, the changing patterns of health care delivery and the changes to the style, content and organisation of education and training. Many R&D findings will have implications for a range of professionals and the role of multiprofessional learning needs to be considered. Further work is needed to explore the effects of developments in education and training on the quality of health care provision.

19. SCOPME welcomes the setting up of broadly-based regional research committees whose role is to advise regional R&D directors on priorities and strategic allocation of R&D funds. SCOPME is concerned, however, that postgraduate training and continuing education are mostly not represented and this may handicap the collection of R&D data, and the dissemination and implementation of R&D findings and recommendations. Effective links at this level with the education and training networks are extremely important.

20. SCOPME considers that the medical royal colleges and postgraduate deans are key players in the dissemination and adoption of R&D findings and recommendations. The colleges have devised and will review the specialty training curricula, following the "Calman" recommendations. These curricula represent important vehicles for the dissemination of accepted R&D findings. Postgraduate deans at present control 50 per cent of the salaries of doctors and dentists in hospital speciality training and this may increase to 100 per cent in due course. They are responsible for the delivery of postgraduate training through programmes meeting the college requirements for specialty training. They also have links to a network of clinical tutors who arrange educational programmes at postgraduate centres which could be used to disseminate R&D initiatives and research findings.

21. The participation of the postgraduate dean at regional strategic R&D level would form a link between R&D and specialty training. Although there is no system for formally designated trainers in hospital specialties (unlike general medical and dental practice), postgraduate deans and the medical royal colleges are in a position to assess the extent to which NHS consultants who train adopt accepted R&D findings and recommendations in their own clinical practice and teaching.

22. Postgraduate deans also control an NHSE allocation for educational research and development in their own regions (0.5 million per year divided between 14 postgraduate deans). Some of this money has been used to appoint educational advisers to the postgraduate deans in line with SCOPME's recommendation. Postgraduate deans have also collaborated in jointly funding educational research that will benefit more than one region.

23. SCOPME welcomes the reference to the role of academic general practice but also wishes to highlight the important role of regional advisers in general practice with their infrastructure of assistant advisers, GP tutors and vocational training course organisers. Regional advisers work closely with regional postgraduate deans to research and develop education for general practitioners. They are also able to influence the dissemination of R&D findings through the PGEA accreditation system. Participation in R&D by general practitioners is also possible through funding available for prolonged study leave.

24. As yet there is no clear mechanism for integrating R&D with continuing education and professional development of career grades in hospitals. Establishing links between R&D, the medical royal colleges and local networks is important.

2. *What is your response to the Culyer report on "Supporting Research and Development in the NHS"? Do you have suggestions, or concerns, as to how it might be implemented? You may wish to comment on service support for curiosity-driven research in NHS hospitals; tertiary referrals in the internal market; the consequences for clinical trials; or any other issues raised by the report.*

25. SCOPME agrees with the views expressed by respondents to the written consultation set out in Part II of the "Culyer" report about the dangers of a compartmentalised, short-term approach to R&D. This parallels the situation facing postgraduate education and training. However, fully transparent funding for both R&D and education and training should help purchasers become aware and accept their responsibility in these areas.

26. It is essential that staff working in different NHS trusts are able and encouraged to co-operate. It is also essential that the needs of R&D and education and training are taken into account when changes in health care delivery are being considered. Sudden, unplanned changes in how and where health care is delivered can have severely detrimental effects on R&D and education and training.

27. SCOPME discussed the impact of the changing clinical environment on both research and education and training. Clinical care is now delivered more quickly in hospitals and more care is delivered in the community. Education and training and research will therefore have to adapt and funding arrangements will have to be flexible to support the necessary changes. There is a danger, highlighted previously by SCOPME in its submission on the Tomlinson enquiry, of moving some types of research into fewer, more specialised "hi-tech" hospitals, separating it from education and training that may increasingly take place within a community setting. These issues need to be considered further but it should be possible to create the same ethos of enquiry, critical appraisal and research in any clinical setting.

28. SCOPME broadly supports the recommendations contained in the "Culyer" report. SCOPME regrets, however, that the Task Force considered that human resource development and dissemination of R&D results (para. 2.71) was outside its terms of reference. A human resource development strategy is important for R&D staff (para. 3.110), but extends wider than this. Many of the points made in the previous section are relevant to this issue.

29. Although SCOPME supports the view that service development is the proper remit of health care purchasers and providers (paras. 3.111–3.119), effective service development relies on effective education and training strategies to support it. A close relationship must develop between the purchasers and providers of health care on the one hand and education and training for all professional groups on the other.

FUNDING

30. SCOPME supports the recommendations for a more explicit funding stream (para. 3.28) for NHS R&D to replace the current diverse funding mechanisms, for the funding stream to be conceived as a levy on health care purchasers (para. 3.30), and for direct and indirect and service costs of R&D in NHS providers to be progressively declared and added to the amount levied (para. 3.38).

31. SCOPME agrees that it is necessary to identify these "hidden" costs but is concerned that the accountancy costs should be kept to a necessary minimum. There is also a need for more research into appropriate methods for costing service support for research. These costings need to be undertaken quickly in order that research progress is not held back.

32. The recommendation for a levy on purchasers parallels proposals for a levy to fund postgraduate training. Purchasers will need to know how and why these funds are being spent and how the results can improve the purchasing of health care.

33. It will be necessary to protect the interests of educational research by ensuring that those judging applications for R&D funds are aware that educational research relies on qualitative methods rather than the strictly quantitative approach used in scientific research.

34. SCOPME considers that there are two issues that need very careful consideration before present arrangements are disturbed:

- a. the funding arrangements for some university academic departments, including some of their staff, currently supported by NHS money;

- b. academics funded by HEFCE contributing to NHS patient care and the training of NHS staff.
35. There are considerable dangers in dismantling existing arrangements before new ones are running efficiently.
36. SCOPME strongly supports the need for service support for curiosity-led research (**para. 3.39**) and financial provision for this needs to be made. A clinical environment in which staff take an active part in quality curiosity-led research is likely to attract high quality staff and benefit education and training.
37. SCOPME welcomes the recommendation that purchasers and NHS trusts can supplement the regional levy and undertake R&D on their own account (**para. 3.41**). The increasingly important role of GP fundholders as purchasers of health care needs to be considered. However, those undertaking or funding R&D outside the main stream should adhere to the same evaluative and process criteria wherever possible.

RESEARCH RATINGS

38. SCOPME supports the recommendation that there should be a formalised assessment by research ratings, similar to those used by the HEFCE, to decide which centres should receive funding for research facilities. SCOPME notes that small changes in research ratings by the HEFCE can have a disproportionate effect on funding. Care should be taken that funding for NHS research infrastructure costs should be kept reasonably constant. Research ratings should not be allowed to stifle research in small units that cannot be categorised in the same way as centres of excellence with established track records. SCOPME points out, however, that the criteria for judging excellence in types of research highly relevant to the broad scope of NHS R&D may have to be rather different from those used to assess excellence in scientific areas. Research ratings should be used as a tool to achieve improvement and not just as an indicator of future funding.
3. *Do you identify additional challenges or opportunities for UK medical research which neither the NHS strategy nor the Culyer report address?*
39. SCOPME has referred previously to the need for research into education and the implementation of the outcomes of research and development. Links between the quality of education and training and the quality of clinical care need to be explored and established.
40. The role of research experience as part of specialty training is the subject of a report pending from the Calman working group. However, the extent to which research experience during training influences how willingly clinicians take on board R&D findings in their career-long clinical practice needs further enquiry. The same applies to identifying the best ways of providing this research experience.
41. The broadening and fragmentation of traditional specialisms, and the move towards a more market-driven strategy based on local needs, with health care purchased increasingly by GP fundholders and provided by the private sector, present formidable challenges to R&D.
42. Funding R&D designed to promote the most cost-effective forms of health care is important but research which might lead to more expensive health care must continue to be supported.
43. SCOPME wishes to draw attention to the European-wide and worldwide agendas for health care that go beyond the immediate needs of the NHS. The UK has a substantial reputation for areas of research, *eg* into tropical diseases, that should not be prejudiced by an R&D strategy based largely on the needs of the NHS.

Note by Professor E J Thomas, Research Co-ordinator and Head of School (Elect), Faculty of Medicine, University of Southampton

This evidence is being presented from my view as the future Head of the School of Medicine at Southampton, an institution which will encompass all clinical research activity in Southampton. For the sake of brevity I have simply presented it as the key points which I believe will be vital to the successful interaction between medical research and the NHS reforms and also to the successful introduction of the recommendations from Supporting Research and Development in the NHS. The evidence centres around those aspects which would be important to success within Southampton; I will not address issues which relate to national factors.

- Clinical evaluative research and development should be accorded equal worth to biomedical research in any assessment exercise whether from the Higher Education Funding Council (E) or the NHS.
- The mechanisms of assessment and funding decisions should be transparent.
- Hospitals and Trusts should invoke internal selectivity based on research activity and resource directorates accordingly.
- Staff appraisal should both address and value research activity.
- Credit should be given to clinicians who support successful research without actually prosecuting it *eg*, by shouldering extra clinical work to enable clinical academics to concentrate on research, by the provision of patients for clinical studies, by the provision of biological materials.

- Nursing, midwifery and professions allied to medicine should be given every encouragement to partake in and initiate evaluative research and development.
- The training of medical and para-medical staff in the techniques of evaluative research and development will be at the core of the long-term success of the initiative.

Letters from Professor J B Swales, Department of Medicine and Therapeutics, University of Leicester

I am writing to express my thanks for the invitation to give oral evidence before the above Committee on 15 February. Lord Walton invited me to submit written comments on my experience as Chairman of the CRDC Cardiovascular Disease and Stroke Programme if I felt these would be helpful. In the event I do not think there is any need to burden your Committee with further paper work as my feelings about the Cardiovascular Disease and Stroke Programme are really embraced by my general views of the R & D Strategy *ie*, that it has been a very considerable success. The Cardiovascular Disease and Stroke Programme is an on-going one, but I believe that the first fruits of that success will be evident within the next year or two.

I also enclose a copy of the paper to which I referred in the journal, *Science Watch*, which is published by the Institute for Scientific Information (*not printed*). I believe I may have slightly misquoted the title of the paper although I believe I expressed the correct meaning. The title as you see should be "Critical Condition: Clinical Research in UK Fading Fast".

16 February 1995

As I mentioned to you in my previous letter I do not think I have a great deal to add about the NHS Cardiovascular Disease and Stroke Commissioned Research Programme. I believe that it has been successful as is shown by the very large number of applications both for the first round and for the second round that is now underway. I was very impressed indeed by the expertise and care exerted by Michael Peckham's staff in support of this programme. The only two points of substance I would make are that for budgetary reasons we had to work to a very tight deadline. This of necessity curbed our discussions. Secondly, the consultation exercise worked well with bodies and individuals who are used to framing and discussing research questions, but consultation with many lay bodies yielded a response which was difficult to convert into fields of research. A more interactive process would have been extremely valuable. We embarked upon this briefly with a single workshop to which interested individuals were invited. This proved extremely useful but time considerations prevented us taking this approach any further. Subsequent Priorities Committees have organised more workshops to help the consultation process.

Lord Walton also asked me to submit in writing views on the Trent Regional R&D Report and Prospective Plan. Since its institution I have been Chairman of the Trent R&D Research Strategy Council and involved with the production of this plan therefore. At Trent RHA we have been fortunate in having a Health Authority that is strongly committed to the support of research. We have the disadvantage perhaps of two medical schools with little in the way of endowment funds available for the support of research. Trent funds therefore assume even greater importance. Our philosophy has been to change the balance of research in the direction of applied health services research. This, however, I must emphasise, has not been at the expense of basic biomedical research and indeed funds in support of this latter activity have been somewhat increased over the last two years. However, extra money has been put into health services research to fund such new developments as the Trent Institute for Health Services Research and the Primary Care Research Focus to which I referred in my evidence. Finally, another major thrust of our strategy has been to support the infrastructure of research through fellowships. We have deliberately spread the type of fellowship offered very broadly. Relatively small sums of money are offered for short courses and training whilst a number of full-time health services research fellowships have been offered at the other end of the spectrum. As I intimated in my evidence the basic philosophy has been to improve the broader culture of research within the Trent RHA's borders and to increase the number of "professional" academics with an interest in health services research. The scheme is too early to monitor any outcomes but the take-up rate has been extremely encouraging.

I hope your Committee find these comments of value.

20 February 1995

Evidence from the University of Manchester Faculty of Medicine

I know that you have received relevant evidence from the CVCP and the Council of Deans of the United Kingdom, which we endorse. In addition, Professor Rodney Harris, the Research and Development Co-ordinator for the Central Manchester Healthcare Trust, which is a major teaching and research institution associated with the University of Manchester Medical School, will send a Trust response which we would also endorse.

However, I have sought views from colleagues within the Medical School and I thought it simplest if I sent to you copies of their responses. These I have enclosed and I hope you find them helpful.

Professor S Tomlinson
Dean of the Faculty of Medicine

11 January 1995

The UK has always been highly regarded for its innovative research. One of the problems has been the subsequent development. The development of an R&D strategy is therefore welcome. However, if it is over-emphasised and too large a slice of the cake is devoted to R&D, too little will be left for innovative research.

In the past I think that we have failed to develop our research findings adequately. My anxiety now is that we have gone too far in the opposite direction.

C S B Galasko,
Professor of Orthopaedic Surgery

1. The NHS R&D Strategy does not yet appear to be working. Many clinical research workers are confused as to what NHS R&D is. We cannot get clear guidelines and it often appears that projects are funded on the basis of who you know rather than the quality of the underlying research.

The NHS appears to be trying to focus research in their priority areas. This is a laudable goal but many members of the key committees do not have a research background and may have difficulty in assessing whether their research objectives can reasonably be met. The objectives are often vague and difficult to achieve.

Many of the best ideas for research and development in the NHS will arise from small groups studying aspects of clinical care (such as autologous transfusion techniques or new approaches to the treatment of venous ulcers). The NHS R&D strategy needs to be able to assess the viability of such projects and then rapidly promulgate the more promising of these. There does not appear to be any clear mechanism by which this can be done.

2. I fear that I am not fully familiar with the Culyer report. The question does raise the issue of service support for curiosity-driven research in NHS Hospitals. This is an issue that I refer to above. There does not appear to be any adequate mechanism by which good ideas generated by clinical workers will get funded. Furthermore, there seems to be a bias in NHS R&D away from funding research in University Departments. This bias should be resisted as it is likely that many good ideas on NHS R&D will arise within University Departments. That is not to say that University Departments should have any priority—research should be funded on merit alone.

3. There are hundreds of opportunities for UK medical research which the NHS strategy appeared to have been conceived to address. For some reason, the development of the NHS strategy has become confused and focussed away from clinical trials and clinical studies. The main focus appears to be a vague concept of NHS management research on health care delivery rather than on clinical research.

I hope that these few comments, although somewhat negative, will be helpful in drafting your response to Tony Heagerty.

Charles McCollum, MD, FRCS
Professor of Surgery

Thank you for sending me a copy of the Call for Evidence.

I am concerned on three counts.

In the first place there is the problem of basic scientific research which is conducted in the Health Service environment. The description as pre-protocol and curiosity driven research are not adequate to describe this type of basic scientific work which has uncertain future application to Health Service needs. I appreciate the argument that this type of research might be better placed in the University environment but the fact is that much of this is undertaken by Clinical Scientists employed by the NHS and it would be a great loss if these people were to be pushed out. In particular under this heading it is essential that the costs of the staff as well as maintaining research facilities not attributable to specific research programmes is maintained.

In this context the funding would seem to be arising from a levy from the purchasers. I am not clear how this will be organised. Any one purchaser is likely not to see this as a priority and it will be essential that there is some overview taken on the funding of this type of research.

A further problem is the need for stability. The nature of the contracting process is very short term; usually of one year. This will make the development of research programmes extremely difficult and in particular

mitigate against long-term planning. Also the nature of short-term contracts is bound to create a lot of uncertainty in the minds of the staff concerned and the worry that they will look elsewhere. There should be at least five-year rolling programmes for the Senior staff.

Malcolm I V Jayson MD, FRCP
Professor of Rheumatology

Thank you for asking for my views on the NHS R&D Strategy, Culyer Report, etc. I would make the following points.

1. Michael Peckham has taken advantage of the existence of the NHS to develop a national research & development strategy for health care. I believe that this has put the UK in the forefront of the development of research strategy in the world. The subjects which have been identified during the first two years of the programme (mental health, cardiovascular disease, physical and complex disabilities, cancer, primary/secondary interface and health technology assessment) offer the possibility of making a major contribution to both effectiveness and cost-effectiveness of health care in this country.
2. The philosophy underpinning the NHS R&D programme is to produce a more knowledge based health care system. While it would be very difficult to argue with this overall aim, the new R&D programme is only three years old and has yet to demonstrate that it can deliver on this.
3. One of the notable features of the way in which R&D strategy has been developed is that this has gone on in wide consultation with purchasers, providers and researchers. There may be a substantial cultural divide between these three groups in their understanding and support for research. Attempting to overcome this divide is a bold move which should be warmly applauded. It is only by overcoming the divide that the research needs of the NHS can adequately be met.
4. My own experience of the wide consultation that has gone on as part of strategy development within the R&D programme is on the health technology assessment programme. Although I have been critical of the process of consultation (eg, in terms of the huge number of organisations that have been consulted and the resulting bureaucracy) I think there is no doubt that the end result has been to produce priorities which are of genuine importance to the NHS. Whether the consultation process has been effective in producing a degree of ownership over those priorities from within the NHS and research communities is more difficult to say.
5. Part of the strategy of the R&D programme has been to try and engage purchasers of health care in setting the research agenda and understanding the importance of research for decisions which they will need to make. The principle that purchasers should take account of scientific output in making purchasing decisions is a very sound one. However it is certainly premature to say that a "research culture" has penetrated purchasers. John James' recent editorial in the *Journal of the Royal College of Physicians* (which questions whether the UK should do clinical research at all) should be evidence enough of this.
6. The Culyer Committee recognises the threat to clinical research posed by the purchaser/provider split, in particular:
 - cost pressures forcing health care providers and purchasers to take a short term view and making them less inclined to invest in R&D;
 - purchasers being reluctant to pay for the service costs or the procedures being evaluated;
 - the increasing tendency not to fund tertiary referrals on which much R&D depends and to support local service providers rather than sending patients to major research centres, so putting independent evaluation at risk;
 - the potential erosion of the clinical research base as a result of diversion of resources towards health services research.

The Culyer report goes a long way towards addressing these issues particularly by the suggestion of a levy on all purchasers to be used for service support of research. The recognition that service support is needed for research in primary and community care is also welcome.
7. My two principal concerns about Culyer are that researchers risk the "double jeopardy" of having first to apply competitively for research funds and then potentially to apply again for service support costs. Ideally, there ought to be a single method of applying both for research and service costs. My second concern is that adequate provision may not have been made to protect tertiary referrals in the Culyer proposals.
8. In terms of opportunities for medical research which are not currently addressed by the NHS R&D strategy or by Culyer, I think there are a number of points:
 - there is clear tension between "science push and needs pull". There is a danger that the emphasis has shifted too much from the former to the latter. The NHS programme does not

seem to be in a position to take a long-term view of research (may be that is right—perhaps that is the responsibility of other research funders).

- Improving understanding of research and use of research results within purchaser and provider communities requires a major cultural change, including widespread acquisition of critical appraisal skills. It is not clear that these have been adequately developed within the programme.
- the main focus of development and dissemination within the NHS R&D programme has been the establishment of the Cochrane Centre and the Reviews and Dissemination Centre in York. Bearing in mind the limited effect of written information in producing behavioural change (certainly among clinicians), it may be that additional input will be needed into implementing change within the Health Service in addition to the rather academic approaches being taken by the Oxford and York Centres.
- there is a lack of coherence at the moment in regional based R&D programmes. This has been particularly obvious within our own region where Mersey and North Western Region took very different approaches to research and development. There appears to be a greater coherence of the national programme than of regional programmes. Perhaps some of this is inevitable, partly because of differences in local needs, and partly because of the limitation of resources which can be put into the development of regional R&D strategy.

9. I think there is some danger of basic biological research being seen as “at odds” with clinical and health services research. If this is the case, it is particularly unfortunate as there has probably never been a time when basic bio-scientific research has come so close to clinical practice, with the extraordinary speed with which new biological advances are being put into clinical practice. There is a very great need for an integrated approach to basic biological research and health services research, and this is not all that evident in the NHS R&D strategy. This contrasts with the MRC which puts quite a lot of effort into trying to integrate these two poles of medical research. I am not quite sure what the role of the NHS programme should be in this respect, but it certainly is not an interface which can be forgotten.

I hope these comments are helpful.

Professor Martin Rowland
Department of General Practice

Evidence from the University of Ulster

The University of Ulster is one of the major providers in the United Kingdom of training in the areas of nursing, biomedical sciences, radiography, optometry, human nutrition, physiotherapy, occupational therapy, speech and language therapy and social work. In addition to undergraduate courses in these areas the University offers a range of taught postgraduate and professional development courses, and many professionals in health related areas undertake full-time and part-time research studies at the University. Indeed the University has recently developed for such candidates taught doctoral programmes in medical and nursing sciences which include a thesis relevant to the professional area. It is also of note that some NHS employees are seconded by the DHSS (NI) to undertake full-time research studies at the University.

In the 1992 Research Assessment Exercise the University entered staff under the units “Other Studies Allied to Medicine” and “Nursing”. Our “Other Studies Allied to Medicine” submission attained a rating of four, and received 20 per cent of the total “QR” funds allocated in the United Kingdom to universities who had submitted under the same Unit. The “Nursing” Unit received a rating of 2 as a developing area, but the University has since deployed funding to encourage the growth of nursing research, and a higher rating is anticipated in the next Research Assessment Exercise.

The University also has a very strong bioengineering centre (the Northern Ireland Bioengineering Centre), the major emphasis of which is the development of medical devices and instrumentation. The Centre brings together clinicians and engineers. In addition there is a close association between the University and the Northern Ireland Regional Medical Physics Agency, the Director holding an honorary chair. In the broad area of health services research the University’s Centre for Health and Social Research has developed particular interests in the interdisciplinary evaluation of health care quality and effectiveness. It has carried out substantial projects commissioned by the DHSS (NI), by the health boards and by several trusts. The University has collaborative research links with all the major hospitals in Northern Ireland and with community health providers, and is also closely associated with a number of research units in Great Britain, including the MRC Dunn Nutrition Centre, Cambridge, the MRC Epidemiology Unit, Cardiff, the MRC Cell Mutation Unit, Sussex, the RCN Standards of Care Unit, Oxford and the King’s Fund, London.

We understand that when the Sub-Committee visited Northern Ireland recently the Queen’s University of Belfast had the opportunity to present evidence—unfortunately, the larger university in Northern Ireland,

the University of Ulster, did not have a similar opportunity. We believe that the University of Ulster can have a major role in taking forward the recommendations in the Culyer Report within the Province. We therefore offer our comments for consideration by the Sub-Committee.

GENERAL COMMENTS

The University of Ulster welcomes the Culyer Report on "Supporting Research and Development in the NHS", and the subsequent announcements by the Secretary of State for Health, in particular:

- the proposal to include the "R" element of SIFTR (STAR in Northern Ireland) with other research monies to create a singly explicit funding stream;
- the proposal that the Director of Research and Development in the Regional Offices should be the focal point for Research and Development within each region, leading a consultative body including local research interests and the NHS service purchasers and providers—we recommend that in Northern Ireland a full-time Director of Research and Development post, independent of the two universities, be established and filled as soon as possible.
- the recommendation that the quality of clinical research be assessed periodically in a way similar to the Research Assessment Exercise.
- the recognition that some NHS settings, in particular primary and community services and professions allied to medicine, have fared less well in developing a research capacity and in securing support for it, and the recommendation that funds for service support as well as for the direct costs of Research and Development are made accessible to those working in these settings (although there is no specific reference to the nursing profession, we assume its intended inclusion).
- the recommendation that support be given to the development of a human resource strategy for Research and Development in the NHS and the emphasis within that on developing Research and Development skills in primary and community care and health professions allied to medicine.

We believe that any new funding mechanism should take into account the real research-related strengths in the universities, and should recognise that these are not confined to medical schools. Researchers and commissioners of research in clinical settings should be encouraged to associate with strong research areas in the universities locally and nationally. Our experience shows that there is potential for synergy between clinicians and scientists, and that in terms of promoting clinical research excellence this interaction may be of more significance than collaborations between clinicians within and without medical schools. The thrust should be to develop through a variety of funding mechanisms close collaborations between NHS settings and highly rated health and biomedical science research units in the universities.

COMMENTS ON THE TRANSCRIPT OF MINUTES OF EVIDENCE TAKEN BEFORE THE SUB-COMMITTEE AT QUEEN'S UNIVERSITY, BELFAST

Having had the opportunity to read the transcript of the minutes of evidence taken before the Sub-Committee during a visit to Northern Ireland on 14 February 1995, we would like to make a few comments.

On page 50 of the proof copy Dr Harbison (for the DHSS) states that "Working through the implementation we must involve purchasers, providers, the university as well as the Department . . ." We would like to stress that there are clear reasons, as outlined above, to involve not only the Queen's University of Belfast, which is the implication, but also the University of Ulster.

On page 55, Lord Butterfield refers to work in health promotion. Health promotion work involves all health professionals and, in Northern Ireland, the two universities. The University of Ulster however is the major provider of dedicated health promotion education, offering a postgraduate Diploma and Master's programme which it is intended to extend to taught Doctorate level.

On page 56, Dr Harbison speaks of trying to "link in the policies and actions of other departments—Environment, Agriculture, Education—increasingly to try and both alert them to their importance in health gain but also to bring, through the alliance concept with other departments, the other key agencies into the whole health gain area". There is clear recognition of the necessity to go beyond the medical schools in implementing the regional strategy, and this is particularly relevant to the University of Ulster.

Lord Butterfield (p57) applauds the intention of involving bright young students in multidisciplinary research. This highlights the opportunities for research students working in nursing and the professions allied to medicine, and in science subjects—the University of Ulster currently has about 60 research students in Biomedical Sciences. Later on (same page) Dr Harbison states that "we need population level information on health and social well-being", and that "we believe we do not have that information adequately". This reinforces the University of Ulster's belief in the need for an interdisciplinary mix in health research and its commitment to both research and teaching which foster the interweaving of professional, managerial and policy imperatives so as to maximise health gain for the population of Northern Ireland.

CONCLUSION

In conclusion, the University of Ulster strongly supports the implementation of the Culyer recommendations in Northern Ireland, involving both universities in the Province as appropriate. We would expect that any research to be commissioned should be open to all relevant research providers in Northern Ireland. We would support a process of peer review for the allocation of funds from the proposed single funding stream, including clinicians and scientists not just from Northern Ireland but also from other parts of the United Kingdom—the scale of funding should be sufficiently large to warrant this.

We note with interest that a “small scoping group” has been established to look at the implementation of Culyer within Northern Ireland. (Dr Harbison’s evidence (p50)), and we offer the University of Ulster’s expertise and experience to that group.

Furthermore, if there is any further information which the Sub-Committee wishes to seek from the University of Ulster, given its experience in health research and the health related professions listed above, we would be very happy to provide it.

Letter from the University of Wales College of Medicine

Thank you very much indeed for the opportunity to submit written evidence to the Select Committee on issues facing NHS R&D in Wales. I understand from Professor Ian Russell that he has already submitted to you a report of the NHS R&D Grants Committee which sat for the first time in Autumn 1994. The recommendations enclosed in the report have been accepted by the Research Development Forum (NHS Wales) and are at present under consideration by the Secretary of State. There are a number of matters which raise considerable concern in the Principality, not least of which is the current absence of a Director of NHS R&D, but we understand that this post is soon to be re-advertised. Among researchers in Wales there are numerous areas of disquiet pertaining to the organisation, commitment and continuity of NHS R&D but clearly these are not going to be resolved until a new director is in post.

It is therefore difficult for me to provide pertinent comment as this would relate to current difficulties rather than the situation that may well pertain when this appointment has been made. If, however, you feel that the current situation requires consideration in greater depth I would be very happy to furnish you with further comment. Please do not hesitate to contact me if I can be of further help to yourself or the committee.

L K Borysiewicz
Professor of Medicine

21 March 1995

Evidence from the University of Warwick

I write to submit evidence to the Sub-Committee on Medical Research and the NHS reforms. Can I say first that the University of Warwick very much welcomes the development of the Research Strategy for the NHS, and the discussion on it. The strategy is securing an important role for research in NHS developments; ensuring that the most relevant work is undertaken; and that it is collated and used to most effect. The various structures, now being put in place, while they must not be allowed to become too bureaucratic and inflexible, help ensure effective research underpinning and delivery.

Warwick already has good links, with the NHS nationally, and with the West Midlands Regional Health Authority. These draw on the University’s strengths in Biological Sciences, Social Studies, Warwick Business School (including the Centre for Health Services Research) and the School of Postgraduate Medical Education. And there are exciting new developments in hand, such as the creation of the Warwick Medical Research Institute which we intend should play a key role in relating research to the needs of the NHS. This will build on the three joint appointments already made by the University and the Walsgrave Hospital Trust including a Professor of Medicine. The University would very much hope to be able to continue and extend its links with the NHS Executive and the RHA both as a research contractor and helping to provide advice from individual members of staff on a personal basis. Please feel free to consult us whenever this would seem helpful to you.

The brief comments below regard four key areas for research: (1) medical research, (2) health technology assessment, (3) organisation and management, and (4) education and training.

- (1) Biomedical research: the techniques of molecular and cellular biology enable a detailed understanding of disease mechanisms and therapies. This underpinning is essential not only in a scientific sense, requiring clinicians and scientists to work closely together but has an important training function whereby clinicians (especially young clinicians) are trained by doing research.
- (2) Health technology assessment: with the shift to HTA there is a need to broaden research skills and support multidisciplinary research which integrates socio-economics and clinical research

methodologies. Particularly important is the need to develop evaluations of cost-effectiveness in the service setting as well as under controlled conditions *eg*, clinical trials. The shift of focus from treatment options at the individual patient level to the evaluation of services as a whole introduces the need for research which requires social science as well as science skills. Furthermore research effort is also needed to develop techniques which can evaluate the relative efficiency of a number of similar organisational units, whether these are departments, GP practices hospitals or districts.

Increasingly, answering "real research questions" in the service setting will require comparison of various combinations of resources with a range of outcome measure. Research methods for valuing these outcomes also need to be developed and evaluated, particularly techniques which can incorporate local preferences. Finally, the implementation process (Getting Research into Practice (GRIP) also requires research into the impact of information in changing behaviour. Research is also needed to identify the most cost-effective means of providing/displaying research findings for use by decision-makers: and to evaluate the extent to which current research findings meet the needs of West Midlands NHS decision-makers particularly when it comes to cost-effective purchase or commissioning of services.

- (3) Organisation and Management: as with (2) an enhanced HSR capacity needs to draw from the social as well as the clinical sciences. Increasingly it is recognised that problems of implementation, strategy and change require such disciplines as organisational behaviour and strategic management to be brought much more firmly into HSR. In particular, the problems of the non implementation of research results has been highlighted nationally by Professor Haines, and this initiative should be reinforced regionally. This raises questions of behaviour change which are best studied through organisation and management studies. There is also the question of system level design, which has assumed great importance in the NHS during the last five years, given recent restructurings.
- (4) Education and Training: there is an increasing need for the provision of post experience training. This requires a more flexible and varied approach to be developed, for example, through offering a more modular approach. Such teaching needs to address problems which emerge from the work of practice as well as offer theory. It needs to address the needs of a variety of groups, NHS managers as well as clinicians. Clinicians moving into management roles also require support. Learners should also expect to develop their own research skills in a research rich setting.

I hope these comments are helpful.

Mark Clark, Industrial Development Officer

28 February 1995

Evidence from the Welsh Office Health Department

1. The Committee has asked for information on the response to the Culyer Report in Wales and on the replacement of the Director of Research and Development for NHS Wales.

CULYER REPORT: IMPLICATIONS FOR WALES

2. Following its issue in England, the Welsh Office Health Department informed Ministers on the background and main recommendations of the report and on how it was to be addressed from a Welsh perspective. Health authorities and members of the NHS Wales R&D Forum were asked to comment from their many different perspectives on how the report should be viewed within Wales. Discussions were held at two formal meetings of the R&D Forum in October and January.

3. Discussions have been held by Welsh Office officials with a range of interested bodies and individuals, including the new Provost of the University of Wales College of Medicine. The Welsh Office has also kept in touch with the Department of Health on how the report is being disseminated and implemented in England. The Executive Committee of the Secretary of State for Wales's Policy Board has considered the outcome of this consultation in broad terms.

4. In seeking views on the report, it was recognised that a number of the main recommendations have already been implemented or addressed in Wales including:

- (a) the creation of an NHS R&D Forum for Wales in 1993 with members drawn from academia, industry, purchasers and providers of health services, together with officials from the Welsh Office;
- (b) the establishment of an Office of R&D for NHS Wales in 1993. The Office has commissioned research against a policy framework developed by Ministers in "Caring for the Future." The first programme of NHS research projects in Wales was announced on 2 March; and
- (c) an existing working group in Wales, involving the Welsh Office, NHS purchasers and providers and the University College of Medicine has been asked to look at the implications in Wales of the Culyer recommendations on funding research and, in particular, the use of the research element of the Service Increment for Teaching and Research.

5. There is a general view that, given the complementary research and development needs of the two countries, and the well developed service and academic links, it would make sense for Wales to adopt a good number of the main recommendations in Culyer. There is a need to see the report in the Welsh context, however. There are different frameworks in operation whether at Governmental level or within the health and research organisations. There is not the complexity of research facilities to be found in England and in particular in London. The University of Wales is therefore in a slightly different position from its counterparts in England.

6. In terms of centrally funded research, Wales presently undertakes this through four main elements. The Department has a share (approximately five per cent) in the England and Wales Centrally Commissioned Programme administered by the Department of Health; it funds a Welsh Scheme for the development of health and social research; it has commissioned research to meet NHS priorities and it has funded research tied to policy directions in areas of community care—for example, the innovative all-Wales strategies for mental illness and mental handicap.

7. The Welsh Office Health Department and the NHS in Wales believe that the recommendations need to be shaped to fit this Welsh context and that implementation of some of the more significant changes should not commence before April, 1996 when the new health authorities will be established. The Department will shortly be considering these issues in detail and would hope to be in a position to confirm the way ahead for Wales by May.

DIRECTOR OF R&D FOR THE NHS IN WALES

8. Following the resignation of the former Director of R&D for NHS Wales, Professor Ian Russell, to take up an appointment at the University of York, the opportunity has been taken to review both the role and the setting of the R&D Office for NHS Wales.

9. It is possible that the existing Office of R&D could be transferred from its location within the Welsh Health Common Services Authority to a new managing authority during the course of 1995–96, if this is consistent with the outcome of the wider Ministerial review of the role and function of the Common Services Authority.

10. A draft remit for the new Office is as follows:

- (a) advise the Welsh Office, following wide consultation, on the priorities for R&D in health and personal social services in Wales;
- (b) commission R&D programmes to meet the agreed priorities;
- (c) manage the programmes within agreed budgets;
- (d) act as a source of information on R&D and disseminate this information to ensure decision makers have timely access to R&D findings;
- (e) advise the NHS and Local Government in a limited number of agreed areas, on the practical implementation of R&D findings;
- (f) advise the NHS and Local Government on any major longer term implications of R&D findings;
- (g) advise the Department on the implementation in Wales of the Culyer Report (or such derivatives of this as are agreed for Wales) and manage defined aspects of implementation;
- (h) achieve a higher profile and reputation for Wales-based research which will attract a larger share of UK funding from the MRC, the private sector etc;
- (i) promote an evidence-based culture in Wales through dialogue with purchasers, providers and the research community both in Wales and the rest of the UK;
- (j) provide effective secretarial service to the R&D Forum which should meet quarterly; and
- (k) take the lead in updating the existing NHS Wales R&D strategy ("Sharpening the Focus") to take account of the wider agenda for R&D in Wales.

11. The following accountabilities are proposed to underpin these new arrangements:

- (a) the managing authority for the Office of R&D would be responsible for performance against contract specifications and would establish management relationships to achieve this;
- (b) the Welsh Office would retain policy responsibility with advice from the R&D Forum;
- (c) the managing authority for the Office of R&D would report quarterly on contract performance to the R&D Forum and then on to the Department;
- (d) the Office of R&D would establish and maintain strong working relationships with senior professional and administrative staff in the health and personal social services departments of the Welsh Office; and
- (e) the R&D Forum would serve as a source of advice and steerage to the R&D Office and would remain an advisory group of the Executive Committee of the Secretary of State's Health Policy Board.

12. When a final decision is taken on the location of the Office of R&D, the managing authority concerned would be encouraged to advertise and fill the post of R&D Director for health and social services.

HMSO publications are available from:

HMSO Publications Centre

(Mail, fax and telephone orders only)

PO Box 276, London SW8 5DT

Telephone orders 0171 873 9090

General enquiries 0171 873 0011

(queuing system in operation for both numbers)

Fax orders 0171 873 8200

HMSO Bookshops

49 High Holborn, London WC1V 6HB

(counter service only)

0171 873 0011 Fax 0171 831 1326

68-69 Bull Street, Birmingham B4 6AD

0121 236 9696 Fax 0121 236 9699

33 Wine Street, Bristol BS1 2BQ

0117 9264306 Fax 0117 9294515

9-21 Princess Street, Manchester M60 8AS

0161 834 7201 Fax 0161 833 0634

16 Arthur Street, Belfast BT1 4GD

01232 238451 Fax 01232 235401

71 Lothian Road, Edinburgh EH3 9AZ

0131 228 4181 Fax 0131 229 2734

The HMSO Oriel Bookshop,

The Friary, Cardiff CF1 4AA

01222 395548 Fax 01222 384347

The Parliamentary Bookshop

12 Bridge Street, Parliament Square,

London SW1A 2JX

Telephone orders 0171 219 3890

General enquiries 0171 219 3890

Fax orders 0171 219 3866

HMSO's Accredited Agents

(see Yellow Pages)

and through good booksellers

©Parliamentary copyright House of Lords 1995

Applications for reproduction should be made to HMSO

ISBN 0 10 482395 X